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ABSTRACT

Although family planning services in rural America are becoming more accessible to women who need and want them, only one-fourth of low- and marginal-income nonmetropolitan women at risk of unintended pregnancy have been served by organized family planning programs. About 150 participants, generally providers of family planning services in nonmetropolitan areas, attended the first National Conference on the Delivery of Family Planning Services in Rural America which concentrated on exploring programs that appeared to have the greatest impact on the expansion of medical family planning services in rural areas. In panel discussions and addresses participants explored questions of costs, manpower, program scale, and program providers. There was consensus on many issues including the similarity of the problems of rural and urban service providers, the fact that the population at risk has differing cultural roots but similar fertility goals, and the need for more financial resources. Appendices include a factbook distributed at the conference which contains data about population, fertility, health resources, and family planning and abortion services. (SB)

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Proceedings of the National Conference on the Delivery of Family Planning Services in Rural America

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Introduction

The first National Conference on the Delivery of Family Planning Services in Rural America, sponsored by The Alan Guttmacher Institute with the support of the W.K. Kellogg Foundation, Battle Creek, Michigan, was held on October 5-7, 1977 in Atlanta, Georgia. Some 150 people participated, most of whom were providers of family planning services in nonmetropolitan areas in the United States.

The Conference represented the culmination of a three year effort in research and technical assistance to aid in expanding family planning services for nonmetropolitan residents. The main purposes of the meeting were to share the findings of AGI's research with family planning providers and decision-makers and to address ways to expand, organize, and finance family planning services in nonmetropolitan areas in the future.

A number of critical questions were explored by panelists, guest speakers and participants: What type of program model is the most effective way of providing care in sparsely settled areas? How do rural programs staff their services? Are costs in urban and rural areas comparable? How do federal and state policies and programs impact on local service providers? Are rural people, programs, agencies. . . substantively different from their urban counterparts?

These Proceedings present the various answers given at the Conference to these questions; as the summary shows, considerable consensus was achieved on a number of these issues. Appended to these Proceedings is a "factbook" that was distributed at the Conference entitled, "The Setting for Delivery of Family Planning Services in Metropolitan and Nonmetropolitan Areas," a compilation of data about population, fertility, health resources, family planning and abortion services.

Conference Summary

Family planning services in rural America are becoming more accessible to women who need and want them, and the historical urban-rural differential in availability has become somewhat narrower. Still, in 1975, only one-fourth of low-and marginal-income nonmetropolitan women at risk of unintended pregnancy has been served by organized family planning programs as compared to four out of 10 metropolitan women at risk.[1]

The Conference concentrated on programs which appeared to have had the greatest impact on expansion of medical family planning services in rural areas. Preliminary research findings presented at the outset showed that while there were urban-rural differences in modes of delivery, the costs of family planning services per patient-year were almost the same, regardless of metropolitan status, about $66 in 1976.[2] Moreover, the findings indicated that the average costs of family planning services in both urban and rural settings has not increased since 1971,[3] despite considerable inflation of other health care costs. Scale was important: programs with very small numbers of patients, and those with very large numbers of patients, were found to be the most costly, suggesting that there might be a size range optimum for cost-efficiency.

Health departments are the principal providers of family planning services outside of metropolitan areas; two out of three patients are cared for by this type of agency. Regionalization of small county health units was presented as one solution to the problem of scale; the example involved a 10-county program with the staff covering literally hundreds of miles in Southern Texas. This program laid heavy emphasis on its community base consistent with the cultural identities of the target population.

Another solution was the development of alternative service providers, in one case, the Colorado statewide Planned Parenthood affiliate, with the capacity for bringing services into remote areas without the encumbrance of the bureaucratic "hassles" which public agencies often encounter, especially if they intend to serve unmarried adolescents. A second model described was an areawide nonprofit corporation, the Southern West Virginia Regional Health Council, which attempted to serve the general health needs of a deprived population. Rural hospitals were mentioned as potential locations for family planning clinics, although it was recognized that on the basis of past performance, it was not likely that large numbers of hospitals could be drawn into the family planning delivery system.

Manpower problems persist in many parts of the U.S., but the Conference participants presented a number of approaches to filling staff needs. In New Hampshire, private physicians have been enlisted to participate in an organized referral program and see family planning patients in their own offices by appointment. In other areas, nurse practitioners are used extensively and are well-accepted by the consumers; in U.S. programs as well as overseas programs, utilization of non-physician personnel appears to be increasing. In some of the communities to which they are assigned, National Health Service Corps physicians are being used to staff family planning clinics.

The major requirement of the providers of rural family planning services who attended the Conference appeared to be *more financial resources*; in this respect, they were no different from their urban counterparts. The state and federal response to this need was expressed in several ways. One state health department official from Oklahoma described their program's flexibility in shifting available financial resources as local programs change and the importance of integrating their family planning programs with their MCH programs. An administrator of third-party reimbursements from Texas urged the expanded use of Title XIX and Title XX for financing family planning services.

Discussion centered around the process which must occur in order to document the needs of the family planning program in a state and to bring these needs to the attention of decision-makers in state houses. Examples from Minnesota, Tennessee and Illinois were presented which suggested the necessity for state agencies to employ staff who have the technical assistance capabilities to assist local programs to expand in the appropriate directions.

Federal funds, regulations and policies were portrayed as fundamental to the success of the family planning programs at the local and state level. Concern was expressed about some of the current practices of the Bureau of Community Health Services (BCHS) which administers Title X funds, particularly the implementation of the Bureau's Common Reporting Requirements (BCRR) and the dismantling of the National Reporting System for Family Planning Services (NRSFPS). Unfortunately, the BCHS director could not attend the Conference; his paper, read into the Proceedings as received, raised many questions relevant to the future funding of family planning programs. The use of family planning funds for the conduct of BCHS's proposed rural health initiative and the utilization of neighborhood health centers as the locus for adolescent family planning programs were two issues about which the Conference participants wanted further clarification.

On the whole, providers of family planning services to rural populations were encountering difficulties similar to urban providers; the population at risk, despite differing cultural roots, apparently have common fertility goals and express their needs with long waiting lines in clinics and for appointments. Thus, all providers appear to need increased resources, as well as technical assistance from the state level, to help unravel the bureaucratic web in which additional financing is often tangled.

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[1] Appendix A, *The Setting for Delivery of Family Planning Services in Metropolitan and Nonmetropolitan Areas* contains detailed tables and charts on population and fertility trends and the distribution of family planning and other services in metropolitan and nonmetropolitan areas.

[2] Tables 1 to 14 on pp. 14 to 21 present the preliminary findings of AGI's study of 256 sample agencies.

[3] See: Westinghouse Population Center, *Comprehensive Report: Cost Study of a Sample of the Grantees of the National Center for Family Planning Services*, HSM 110-71-219. Westinghouse Population Center, Columbia, Maryland, 1972.

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Opening Remarks

FREDERICK S. JAFFE

President
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Thank you all for coming. It's good to see you again. This Conference represents for us the culmination of a three year project which has been supported by the Kellogg Foundation, basically to examine the deficits in the provision of family planning services in rural America and to explore ways of remedying them.

The fact that the provision of family planning services in metropolitan areas is more advanced than nonmetropolitan areas is by itself hardly surprising. In our nation, nonmetropolitan areas generally have less of almost everything—less of all health and public services. So, the focus of the project is not to belabor the obvious, but to analyze as best we could what accounts for differences. The project was begun at a time when the federal government was seeking to end its direct involvement with local human service programs. That policy came to be known as the New Federalism under the Nixon and Ford Administrations. As far as I know that policy has not yet been given a different label by the Carter Administration.

Given this continuing stance by the federal government, the development of family planning services in nonmetropolitan counties appeared to depend, and still does appear to depend very heavily, on the initiative of state family planning agencies, governmental and private. Some agency at the state level has to take responsibility for obtaining the necessary resources, for providing assistance and direction to local agencies, and for evaluating and reporting progress, or, for that matter, sometimes lack of progress.

So our project has encompassed a number of sub-projects which explored issues related to statewide programs. We developed a handbook on how to prepare a statewide plan for family planning services, and in one largely rural state, we tested out the methodology in cooperation with a council representing providers and consumers in that state. We prepared and distributed profiles which succinctly summarized the status of the program in each state and focused attention particularly on deficits in nonmetropolitan counties. We have provided technical assistance or consultation directly to providers in at least 13 states, in some cases offering training as well as technical assistance and consultation. During the past year we have been working on a summary study to evaluate the effectiveness and efficiency of nonmetropolitan programs and to determine if they are different, and if so, in what ways, from programs in metropolitan areas. Our staff will present the first findings of this study for consideration at this Conference, and we hope to share with you other impressions, judgments and maybe even something called "knowledge" that we've gained in the course of the project.

We are very pleased that Dr. Robert Sparks of the Kellogg Foundation is participating in this Conference so he may learn first-hand about the vitality of nonmetropolitan area family planning programs and the problems that they face.

It was 10 years and one month ago that the President's National Advisory Commission on Rural Poverty issued its report entitled "The People Left Behind." This Conference, in a sense, provides an opportunity to measure changes in the last decade. The commission made 12 recommendations for national initiatives to improve the lives and prospects of the rural poor. One of them was for a federal program to appropriate earmarked funds for expanded family planning services for low-income persons in both our cities and our rural areas. The commission called for programs to be established in rural hospitals and health departments. In a passage which may seem routine today but was far from routine a decade ago, the commission urged, and I quote, ". . . that special programs be developed to provide social, health, and educational services to young boys and girls to reduce the incidence of illegitimate births and early marriages necessitated by pregnancy." The commission also took a look at the then existing rural family planning programs and from that look they concluded, "These programs have demonstrated the demand for the feasibility of family planning services in rural areas. They have also shown how much can be done with little staff and funds. A variety of approaches have been used in these different projects to suit the needs of different communities, such as health teams with sub-professional assistance, and providing transportation and mobile units to reach people where they live when it's not feasible to establish a permanent clinic."

How far have we come since that landmark report? The facts before you provide some very interesting measures. Nearly one million women, mostly with low and marginal incomes, were served in nonmetropolitan family planning programs in 1975. That's seven times the number served in 1968. The rate of growth of the family planning caseload in nonmetropolitan areas has, in fact, been greater than the rate of growth of the caseload in metropolitan areas. Family planning programs are now located in four out of five nonmetropolitan counties.

These are impressive gains, and they should lay to rest several of the underlying myths about rural areas that were prevalent a decade ago, and, like most things in the world we live in, are still prevalent and still affect the thinking of at least some decision-makers. Some believed then that an effort to expand rural family planning services would fail, both because the rural poor wanted large families, and therefore didn't want family planning, and because there were not enough doctors and nurses and other health resources in rural areas to draw on for family planning programs. The experience of the last decade is that rural poor women in all ethnic groups respond just as eagerly as the city poor to the availability of services, and that even modest state and federal funds can marshall or create significant human and institutional resources for development of the program.

If the data were available for a comparative evaluation, I believe that they would show that family planning clinic services are now more widely diffused through the nonmetropolitan areas of our country than any other federal health program, and that, too, is no small achievement. But there is still a long way to go before everyone who risks an unwanted pregnancy in nonmetropolitan areas has access to modern family planning services. In the information which you have in our factbook you will see at least one and a half million nonmetropolitan low- and marginal-income women in need of services, and probably another 300,000 or 400,000 sexually active teenagers in higher income families, could not obtain services from either clinics or private physicians in 1975, which is the last year we have data. It couldn't be much different in 1976 or 1977.

Everything that has happened in this program in nonmetropolitan areas in the last 10 years should give us confidence that these women would utilize the services if made available, and that existing programs in nonmetropolitan areas could expand rapidly to get the job done if they had sufficient support from the federal and state governments.

So, our principal purpose in this Conference is to share experience in nonmetropolitan programs so that we're in a better position to describe how the critical task of providing the needed services could be accomplished. Our examination of the factors that have contributed to the greater success of some programs may shed some light on what are, perhaps, the central overall policy questions remaining to be answered: "Do nonmetropolitan areas or residents have such special characteristics that rural family planning programs have to be designed and carried out in ways uniquely different from metropolitan area programs? If they do, what are the special characteristics? What are the program differences to deal with them? And what are the differences required in federal and state programs? If they do not, is the implication that services could be extended to all nonmetropolitan residents needing them by doing essentially what we have been doing, only better and more, that is, by utilizing current models of service delivery, and expanding with greater priority, funds and attention from the federal and state government? Do nonmetropolitan programs cost more than metropolitan programs, so much more in fact that it is too expensive to provide the services?" You hear that kind of argument when you talk about nonmetropolitan programs with policy makers in Washington.

Finally, a question like, "Is the conservatism associated with nonmetropolitan areas true about our patients and prospective patients, that is, are they very wary about using these services? Is it true about the gatekeepers who control the institutions and resources in nonmetropolitan counties? Or is it true for neither group? And, if it is true for the gatekeepers, how can their resistance be overcome?" I hope we will find time during this Conference to answer these questions and explore the role that nonmetropolitan family planning providers can and must play in delivering family planning services to all the women who need and want them.

Remarks

ROBERT D. SPARKS, M.D.

Program Director
W.K. Kellogg Foundation

The Kellogg Foundation is extremely pleased to have supported The Alan Guttmacher Institute's project which, over the past three years, has sought to assess the "state of the art" in the delivery of family planning services in rural America and to test out ways of extending services to rural women who need and want them. I'm personally grateful for the opportunity to participate in this Conference with you. Too often we get so involved with the paper work of program analysis and evaluation that we have little chance to meet the people actually running the kinds of programs we try to encourage.

Our main interests at the Kellogg Foundation are in programs in agriculture, education and health, and we emphasize the application of knowledge in these fields. It would be difficult to imagine a project that fuses all these areas of interest to a greater degree than does this one in rural family planning. The basic problem of unwanted births itself results from failure to apply the knowledge we have of how to control family size. The knowledge is there, but the application, through a network of service delivery and educational opportunities, is lacking. Thanks primarily to a combination of federal funding, active women's and consumer groups, and the dedicated efforts of family planning provider agencies, this knowledge has been disseminated through family planning programs throughout our country in a very short period of time. And, as we will undoubtedly learn in detail at this Conference, there has been a substantial amount of activity—and success—in rural areas. But, in large part because these areas are sparsely populated and have few resources, the problems of service delivery, access to care and financing are more difficult than in urban areas.

Let me just add a brief comment here. Joy said I'm the delegate from Battle Creek, today. I see a few other people from the state of Michigan, so I'll confine it to Battle Creek. Mr. Kellogg grew up in Battle Creek. As he became successful in the world of the cereal industry, an industry which he created, he dedicated his philanthropies to, first of all, Battle Creek and the southwestern portion of Michigan. With the success of the industry and that philanthropy as he appreciated it, he then moved on to broader horizons in the country and, in large measure, the world. But, as he did that, he made two provisions. One was that both the company and then this Foundation, which is separate from it, would always remain in Battle Creek. He provided that by stating that they would hold monthly meetings in Battle Creek. In order to change that, you are going to have to change provisions of the trust, and I don't think anyone wants to fool with that. So, his attention was clearly on small communities.

As I came to the Foundation, I took an opportunity to look at the distribution of the population of this country. In the data that you have, you will see this discussion of the metropolitan-nonmetropolitan distribution of our population. There is a slight twist on that. If you go through the census listing of communities in this country, you'll discover that we like to be identified by those individual communities, and even though we live in a community that is counted as a part of a metropolitan area, we tend to look upon ourselves as a resident of that community. We are only going to Detroit for the symphony or for the football games, or what-have-you, and don't really look on that as our community of support. And if you look at the census listing, I think you'll discover that, certainly by the 1970 census data, just slightly more than half of the people in the U.S. lived in communities of 25,000 population or less. I think that is an observation that is important. Some of the current federal legislation, which does tend to focus on the urban areas, particularly in the field of health, acts as if our country is predominantly metropolitan. It surely is if you count it by the census data, but I think there is a little twist on that that we've overlooked.

So, Mr. Kellogg was concerned about the application of knowledge and the benefits of knowledge that should be brought to those smaller communities. I grew up in one of those, and I can tell you that it is still rural, by anybody's definition.

At our Foundation we try to emphasize W.K. Kellogg's philosophy of doing "the greatest good for the greatest number of people," and we believe that this broad area of population and family planning is noteworthy in this regard. Based on a brief glance at the factbook, I note that your efforts in this direction to date are, in many states and counties, impressive and exemplary. I'm extremely pleased to see that we'll be hearing from a panel of providers, and can, perhaps, extract some problem-solving examples to emulate in other areas where the family planning program has not been so successful, or where it has not even really begun. As I indicated earlier, I'm here to learn firsthand. I anticipate hearing about your successes and your failures. I imagine that this group has learned from both.

John Gardner in his essay on self-renewal said it well: "There is a mistake in a conception of efficiency that sees pluralistic approaches as wasteful and confusing. The need for efficiency is not to be laughed off, of course. In a grim world free societies must prove their capacity to function efficiently. Extremes of pluralism can lead to utter confusion, but creative organizations or societies are rarely tidy. Some tolerance for inconsistencies, for profusions of purposes and strategies, and for conflict is the price of freedom and vitality."

Surely this Conference will witness plurality of points of views. No points can be shouted out on emotion. Rather all points of view and ideas must be subjected to vigorous scrutiny or objectivity and truth. We at the Kellogg Foundation expect to share with all of you in the creativity and the knowledge that is to be displayed in the deliberations which will be essential to the success of this Conference. I'm pleased to be here; I look forward to the participation that I'll have in sharing with you.

Panel Discussion

Family Planning in Rural America Today: Overview

Moderator:	Frederick S. Jaffe President The Alan Guttmacher Institute
Participants:	Susan Eisman Planning Associate The Alan Guttmacher Institute
	Donna Friedman Planning Assistant The Alan Guttmacher Institute
Reactor:	Thomas Webber Executive Director Planned Parenthood of Minnesota

Family Planning Services in Nonmetropolitan Areas

SUSAN EISMAN

Planning Associate
The Alan Guttmacher Institute

In order to provide a framework for our discussions at this Conference, I'm going to briefly describe the current status of family planning service provision in nonmetropolitan areas. My remarks will be based mainly on tables which appear in "The Setting for Delivery of Family Planning Services in Metropolitan and Nonmetropolitan Areas," what we call the "factbook." This factbook contains data from our files for all identified family planning providers plus information about population and fertility trends, health services resources and utilization and abortion services in metropolitan and nonmetropolitan areas.

Everyone defines metropolitan and nonmetropolitan differently. Just to make sure that we're all speaking the same language, we're referring to the definition of metropolitan areas used by the Census Bureau, which is "a standard metropolitan statistical area is a county or group of contiguous counties which contains at least one city of 50,000 inhabitants or more, or "twin cities" with a combined population of at least 50,000." Nonmetropolitan areas, then, are those not in a SMSA. I'll also be mentioning "regional breakdowns." The map on page 89 of the factbook clarifies what I mean in case you'd like to refer to it.

I'll begin with a summary of some recent demographic data that shapes our discussion of the nonmetropolitan areas. Of the total population in the U.S., while only about 27 percent live in nonmetropolitan areas, nearly one-half of the people in the West North Central states—which cover the territory from North Dakota to Missouri—and one-third of the southern population live in nonmetropolitan areas. While half this population lives in counties with no city or town larger than 10,000 people, very few actually live on farms. Nonmetropolitan areas contain one-third of the white, one-quarter of the black and 18 percent of the Hispanic population. More than 15 percent of the nonmetropolitan population is below the poverty level compared to only 11 percent of the metropolitan population. It's more significant to note that central cities and nonmetropolitan areas have about equal percentages of residents below the poverty level. We were able to get some special tabulations of low-income women of childbearing age in nonmetropolitan areas. It is of special interest to us that while 30 percent of all women aged 15-44 live in nonmetropolitan areas, 36 percent of low-income women of childbearing age are nonmetropolitan residents. More than one-quarter of these low-income nonmetropolitan women are below the age of 20, and almost seven in 10 of them are white.

While nonmetropolitan fertility rates declined at a rapid rate in the 60's, narrowing the previous rural-urban fertility differential, the overall nonmetropolitan birth rate is still higher than the metropolitan one. Women in nonmetropolitan areas expect to have slightly more children than do urban women, but this difference disappears in the younger age populations. Young wives, metropolitan and nonmetropolitan, aged 18-24, currently expect only 2.1 children. Their fertility expectations are almost identical. The only notable difference is that nonmetropolitan wives have their children at earlier ages.

Now I'd like to give you some background on the family planning delivery system. We define "women in need" of family planning services as those women who are, first, at risk of unwanted pregnancy due to being sexually active, fertile and not pregnant or trying to become pregnant with a wanted child; and second, have family incomes at or below twice the federal poverty level. (That is—about $11,000 for a non-farm family of four and $9,390 for a farm family in 1975.) Nationwide, there are 10 million women in need and about four million served. In nonmetropolitan areas, we estimate approximately 3.4 million women in need in 1975, with almost one million served, 89 percent of whom we estimate to have low and marginal incomes. That's about 837,000 low- and marginal-income nonmetropolitan women served!

Nonmetropolitan areas contain 35 percent of the women in need of family planning services, 25 percent of the patients, and 40 percent of those unserved by organized programs. In other words, 2.6 million nonmetropolitan women were not served by organized programs in 1975. There is a great deal of regional variation in terms of the proportion of this need which is met by organized programs. While one-half of the women in need live in the South, this area provided 61 percent of total nonmetropolitan services. The North Central area, on the other hand, provides only about 14 percent of total nonmetropolitan services but contains 26 percent of the nonmetropolitan women in need.

We know quite a lot about the family planning services provided by clinic programs but very little about the same services provided by private physicians. We are aware that private physicians play an important role in bringing health care to low-income families in nonmetropolitan areas where there are few other sources of organized medical care. Though it might be expected that these doctors would also play a major role in provision of family planning care to low- and marginal-income women, data from the National Ambulatory Medical Care Survey in 1973 suggest that the level of private physician care in regard to family planning services is lower in nonmetropolitan areas than in metropolitan areas. Overall in the U.S. we assume that 20 to 30 percent of the women in need received family planning care from their private physicians, but we have no accurate measure of metropolitan-nonmetropolitan differences in this group.

As I pointed out above, at the end of 1975, one-quarter of the nonmetropolitan women in need were receiving family planning services from organized programs, compared to 40 percent of similar metropolitan women. Even assuming that 700,000 to one million women may have received care from private physicians, the unmet need is still great. While this unmet need for family planning services in nonmetropolitan areas is nationwide, some states have been more successful in expanding organized programs to meet this need than others. According to our most recent estimates, more than 40 percent of nonmetropolitan women in need were served in five diverse states: Alaska, California, Hawaii, Tennessee and Vermont. In five other states, however, less than one in 10 nonmetropolitan women in need were served; these states were Utah, Wisconsin, Indiana, Illinois and North Dakota. There were other states where the need in terms of sheer numbers of women is so great that despite active and expanding family planning programs, over 100,000 nonmetropolitan women remain unserved; this is the situation in North Carolina, Texas, Mississippi and Pennsylvania.

We're not saying that there haven't been significant improvements in nonmetropolitan areas. Since 1968 the number of nonmetropolitan women served by organized family planning programs has increased seven-fold. Nonmetropolitan programs increased their percentage of the caseload from 17 percent in 1968 to 25 percent in 1975. Some states increased their percentage of nonmetropolitan women in need served by more than 10 percent in one year. These include Wyoming, Tennessee, Oregon, New Jersey, Massachusetts, Hawaii, and Georgia. This certainly indicates that nonmetropolitan programs can make incredible strides in increasing their coverage of low- and marginal-income women in need given adequate resources.

Family planning services in this country are provided by four types of provider agencies—hospitals, health departments, Planned Parenthood, and other agencies (which include community action agencies, neighborhood health centers, free clinics, women's health centers, and specifically incorporated family planning programs). In nonmetropolitan areas we have identified 1,400 agencies and 2,500 clinic sites. The distribution of patients among agency types differs in metropolitan and nonmetropolitan counties and varies a great deal from region to region. Health departments are the principal service providers outside of SMSAs; nationwide two out of three nonmetropolitan patients receive services from this type of agency. At the other extreme are the hospitals, where service is provided to only four percent of the nonmetropolitan caseload, ranging regionally from zero to 13 percent. In two regions, *no* nonmetropolitan hospitals could be identified as service providers. Planned Parenthood, while largely based in metropolitan areas, does serve 11 percent of the nonmetropolitan patients, some of them through a cross-over effect whereby nonmetropolitan clinics are operated by metropolitan-based agencies. Regionally, the proportion of nonmetropolitan women served by Planned Parenthood varies significantly—from zero to 47 percent. "Other agencies" served 19 percent of the nonmetropolitan need; two-thirds of the women in New England were served by such agencies.

Analysis of data for individual states indicates that, although a mix of agency types tends to predominate in the metropolitan areas, the nonmetropolitan areas are more likely to be served by a single agency. In most states where a single agency type dominated, it was the health department, but Planned Parenthood affiliates served two-thirds or more of the nonmetropolitan caseload in seven states, and in six states, the bulk of nonmetropolitan patients received care from "other" agencies (mostly community action). In only five states with very low populations did hospitals serve more than 18 percent of the need; in 27 states, no family planning patients were served by hospitals.

As far as provision of abortion services, there is a glaring metropolitan-nonmetropolitan differential—only five percent of all legal abortions were obtained in nonmetropolitan areas in 1976, yet 25 percent of women in need of abortions live outside SMSAs. Estimates are that nearly 80 percent of the need for abortions is met in the metropolitan areas but only 14 percent in nonmetropolitan areas. We all know that some nonmetropolitan women obtain abortions in metropolitan areas, but it has been demonstrated that the further a woman must travel to get an abortion, the less likely she is to do so—another indication that the unmet need remains great in nonmetropolitan areas. An increasing proportion of abortions are provided by free-standing clinics in both metropolitan and nonmetropolitan areas; in fact, almost one-half of the nonmetropolitan abortions performed in the first quarter of 1976 were in such clinics. Along with this development, the proportion of abortions performed in hospitals, both public and private, is declining. Since it is unlikely that free-standing clinics will be able to expand into all the rural and small-town areas where they are needed, these declining hospital rates are symptomatic of a continuing unmet need for abortions in nonmetropolitan areas.

One of the early goals of the federal family planning program was to establish a family planning service site within a convenient distance of each woman in need; by 1975, four-fifths of U.S. counties had been covered, compared to only 56 percent in 1971. However, 94 percent of these no-service counties are in nonmetropolitan areas, and they're not all so small. Seventy-eight of these counties without service have more than 1,000 women in need, while in another 151 counties, between 500 and 1,000 women are in need.

I've only been able to touch the highlights in this brief discussion of the nonmetropolitan family planning delivery system. I do want to stress the wide variation, regionally as well as by state, in both proportion of women served and in type of dominant provider agency. The factbook covers many of the areas I've discussed in greater detail; if any of you have specific questions about your county or state, our staff will be available throughout the Conference.

Preliminary Findings of the Rural Evaluation Study

DONNA FRIEDMAN

Planning Assistant
The Alan Guttmacher Institute

The evaluation study which I will discuss today is part of the series of studies conducted under the sponsorship of the Kellogg Foundation. This study is based on the assumption that agencies providing family planning may have certain definable characteristics related to relative success in recruiting and providing family planning services to women in need. Thus, we aimed to describe the characteristics of the nonmetropolitan family planning delivery network, examine how nonmetropolitan provider agencies use the resources available to them, and evaluate the comparative efficiency of different ways of providing services. We were particularly interested in determining what the role of state programs could be in developing comprehensive statewide family planning programs. Our hope is that through such analyses and evaluation, suggestions for new or enhanced ways of expanding services in nonmetropolitan areas will emerge.

Today I will be discussing the preliminary research findings and will be able to present only some conclusions from the data, all of which will be published in the Spring. Tables for the material I'll be using are in your packet—they are the ones with the gold cover. AGI staff will be glad to answer any further questions you have about our survey; and Regina Loewenstein of Columbia University School of Public Health, our statistical consultant, is here if you have any methodological questions. For those of you interested in the methodology of this study, a technical appendix is available upon request.

Let me spend a brief moment to remind us all of a couple of definitions used in today's discussion and then briefly explain a bit of our methodology. Metropolitan counties are those which are part of a Standard Metropolitan Statistical Area. Nonmetropolitan provider agencies include both those agencies operating only in nonmetropolitan areas and metropolitan-based agencies which operate at least one service site in a nonmetropolitan area.

Data for this study were collected with a mailed survey instrument sent to a stratified random sample of agencies directly responsible for family planning service provision in the U.S. Many of you are familiar with this instrument, since you represent agencies which received and completed the survey.

The universe from which we sampled is stored in The Alan Guttmacher Institute family planning data files. Two separate sample frames were used in drawing the sample—one for nonmetro agencies and the other for metro providers. Each sample frame was stratified by type of agency: hospital, health department, Planned Parenthood affiliate and "other" agencies—including community action agencies, neighborhood health centers, free clinics, women's health centers, and specifically-incorporated family planning programs.

Our sampling methodology called for selection of 100 agencies of each type. In total, 684 agencies were surveyed, and we expected that response rates would be no more than 50 percent.

Table 1 shows survey response rates by type of agency. Final responses include questionnaires completed by 256 agencies—143 metro and 113 nonmetro. These respondents represent 38 percent of the total agencies surveyed and three-quarters of the "desired response rate." Given the length and detail of the survey format, and in view of past experience, this response was not unexpected. Actually, to the best of our knowledge, the final sample represents the largest cross-section of family planning agencies yet studied in such detail. Unfortunately, the low response among nonmetropolitan hospitals makes it impossible to analyze these agencies as a separate group. On the tables, we have used an asterisk to indicate all cases where data are unreliable due to small sample size.

The analyses presented here were weighted to represent the universe of 2,500 agencies, based on the 256 responses. All sample data were inflated and adjusted to reflect the true number and distribution of family planning provider agencies in the U.S., by agency type and by metro status. However, even when weighted, the survey sample does not conform exactly to the universe of family planning provider agencies. Table 2 shows that it slightly underestimates the number of metropolitan agencies which have sites in nonmetro areas and overestimates the number of single-site agencies—those having only one location where family planning services are provided.

Table 3 displays summary data for the major variables to be discussed in this report. Table 4 is available for those of you who wish to compute confidence intervals around the variables. We can see that, because of the diversity in the delivery system, there is a wide range of values among respondents for any given variable. In certain instances, we calculated both average and median responses. I'll try to make clear which response I am discussing as we proceed.

There are some additional limitations in collecting detailed statistical data via a mailed survey. Definitions used by respondents may vary, and estimates may be reported in lieu of "real" information. During editing, we carefully checked for discrepancies and resolved any identified problems over the phone.

We specifically asked agencies to estimate their costs of providing service, including their estimated expenditures and in-kind services received—such as contributed time of volunteers, space, lab services, or supplies donated or paid for by another agency. All responses were carefully edited to make sure that these costs for in-kind were included. Since most respondents did not have results of specific cost studies, agency costs by type of activity probably included considerable estimated data: 28 percent of the respondents could not provide any data on total cost of family planning, and 33 percent could not provide information on costs by activity. Many respondents were able to provide some, but not all, of the information requested; therefore the response rates varied for each of the financial and cost variables.

And now let's turn to the findings. Sue Eisman and many others have noted that nonmetropolitan areas are comparatively less well served than metropolitan counties. Only 25 percent of the nonmetro need was served by organized programs compared to 40 percent of the metro need. A brief examination of the characteristics of the metro and nonmetro delivery systems provides a framework within which differences in efficiency of agencies can be considered.

Figure A summarizes the characteristics of the different types of agencies providing family planning services in metropolitan and nonmetropolitan areas. Based on these data, the delivery systems might be characterized in the following manner:

1. The nonmetro system is overwhelmingly a health department system; these agencies constitute three-quarters of providers in nonmetro areas. The metropolitan system has a greater mix of agencies, with no single agency playing such a dominant role.
2. The majority of metro and nonmetro agencies operate one location where family planning services are available. Among the multi-site agencies—those with more than one service site—nonmetropolitan providers tend to have fewer sites. Half the nonmetro multi-site agencies have 3.8 or fewer sites, compared with 4.8 sites for metro multi-site agencies.
3. While nine out of 10 providers operate only in one county, the nonmetropolitan agencies are more likely to serve a multi-county area. The nonmetro agencies which have service sites in more than one county tend to cover a larger geographic area—an average of 4.6 counties, or twice the counties covered by the average metro multi-site agency.
4. Nonmetropolitan agencies tend to have small caseloads, but more of their patients are poor. Fifty-six percent of the nonmetro agencies served fewer than 500 family planning patients, compared with only 14 percent of the metro agencies. Almost half the nonmetro providers have no patients with reported incomes above $10,000, compared with roughly one-quarter of the metropolitan providers.
5. If we look at Table 5, we find that nearly two-thirds of nonmetropolitan agencies are the sole providers of family planning services in their catchment areas. This is true for only about one-fifth of metro programs; the remaining four-fifths are in areas where more than one provider is at work.
6. Table 6 shows us that nonmetro providers typically operate in counties where the total number of women in need is smaller than the number in metro counties.
7. We looked at the percent of women in need served by organized programs in the catchment areas by our sample agencies and found that nonmetropolitan agencies were not doing as well as metro agencies. Table 7 shows that 44 percent of nonmetro agencies were in low success areas compared to 22 percent of metropolitan. In nonmetropolitan areas, agencies working in a multi-provider setting did a lot better than single providers—only 29 percent of multi-providers were in low success areas compared to more than half of single-providers.

Since health departments play such a dominant role in the provision of service to nonmetropolitan residents, it is worth our taking a closer look at these agencies in Figure A. Three-quarters have only one service site and 95 percent operate in one county. They have particularly small programs—65 percent have caseloads of under 500 patients. In contrast, Planned Parenthood affiliates and "other agencies" are more likely to be multi-site and/or multi-county. Most of the Planned Parenthood affiliates served more than 1,500 patients. Although the "other agencies" tended towards smaller caseloads than Planned Parenthoods, one-third served more than 1,500 patients (Figure A).

We should also note here the relatively important role of community action agencies in the nonmetropolitan system. These agencies account for more than half of the nonmetro "other agencies," and 31 percent of the metro. Neighborhood health centers play a minor role among nonmetro providers, accounting for only three percent of all other agencies. Thus, in the nonmetro system, the term "other agencies" refers mainly to community action agencies and specifically-incorporated family planning programs.

Let's move next to financing and costs of service. One of the most important issues in service provision is use of available resources. Do metropolitan and nonmetropolitan agencies differ in the ways they finance their family planning services? Do costs of service provision differ between metro and nonmetro areas and, if so, what factors seem to have the greatest influence on costs?

Given the average caseload size, we would expect metropolitan programs to have much higher budgeted costs than nonmetropolitan, and they do. The median budget, including in-kind costs, in nonmetro areas is $43,500, compared to $153,000 in metro areas. Table 8 shows that 70 percent of nonmetropolitan agencies have total costs of under $75,000, compared to 16 percent of metro agencies. The small proportion of high-budget nonmetropolitan providers are almost all metropolitan-based agencies with nonmetropolitan sites.

Agencies use a variety of resources to finance family planning services. Table 9 summarizes the available study data on differing use of resources by metropolitan and nonmetropolitan providers. It shows the proportion of agencies receiving funds from five major sources, the average proportion of budget received from these sources and the average and median amounts received. Since different agencies use different sources, the percents of budget do not add up to 100.

The smaller amounts received from each source by nonmetropolitan agencies is not surprising, given the small caseloads and total budgets of these agencies. The data do point towards interesting differences in the mix of funds supporting services in metro and nonmetro areas.

Nonmetropolitan providers are somewhat less likely to have federal family planning grant funds than metro agencies—69 percent compared with 77 percent of metropolitan agencies; but the difference is not significant. On the other hand, nonmetropolitan agencies are much more likely to receive state health department funds. Forty-three percent of the nonmetro providers have state health department grants, compared with 28 percent of metro providers.[1] Fewer nonmetropolitan providers receive Title XIX Medicaid funds but there is little difference in regard to Title XX funds.

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[1] State funds do not include any Title X/V family planning funds administered by state health departments. They do include MCH formula funds, special appropriations and general tax revenue.

Patient fees were collected by only one-third of the nonmetropolitan providers. This may be partially explained by the role of local health departments, many of which have had a long-standing policy of not charging for services. In fact, almost four-fifths of nonmetropolitan health departments had no patient fee revenue.

Perhaps more significant than whether funds are received from a source is how much of the budget comes from that source. While all agencies receiving federal or state grants draw more than half their funds from these sources, nonmetro providers seem to rely more heavily on grants than do metro agencies. This is particularly apparent when looking at state health department grants. The average nonmetropolitan agency with state health department funds draws over three-fifths of its budget from this source, while a comparable metropolitan agency receiving these funds draws slightly over one-third of its budget from this source.

While Title XIX Medicaid reimbursement makes up a very small proportion of total resources for all agencies, Title XX seems to be a more important component of the funding package for those metro and nonmetro agencies which do receive such monies. Finally, a very small proportion of agency budgets come from patient fees, regardless of their location.

From the table, it appears that state health departments play an important role in financing services in nonmetropolitan areas. In addition to allocating their own funds, many state health departments also receive and disburse Title X funds. The data indicate that three-fifths of the nonmetropolitan providers with federal Title X funds receive these grant funds through the state health department. In comparison, about one-third of metropolitan providers with federal funds got their money from the state health department.

In this picture, we can also add the role of Title XX—a state-planned and controlled program. While the proportion of agencies receiving Title XX funds does not vary by metro status, it is worth noting that nonmetro agencies began receiving these funds recently; 93 percent started receiving Title XX funds between 1975 and 1977, compared with 62 percent of metro agencies. These data suggest that the changeover from Title IV-A to Title XX (which occurred in 1974-75) may have had a greater impact on nonmetropolitan areas.

I would like to talk to you now about program efficiency. Efficiency in use of resources is usually measured as costs per unit of service. In family planning, this means cost per patient or cost per visit with total cost calculated to include expenditures and in-kind contributions, such as volunteer services. Since 1971, when the *Westinghouse Cost Study of the Grantees of the National Center for Family Planning Services* was conducted, the family planning field has been operating without a firm fix on the cost per patient. In the absence of any large scale studies, it has been assumed that the cost per patient for family planning service provision is higher in nonmetropolitan areas. In fact, when we began this study, several rural program directors suggested to us that cost per patient was not an accurate measure of their programs; they told us that, since their programs tended to have higher visits per patient than programs in more urbanized settings, cost per visit would be a more accurate reflection of their operations than cost per patient.

From what I've just said, you may have already guessed what our study results show. Contrary to common belief, this study suggests that it is *not more expensive* to provide family planning services in nonmetropolitan areas. Results indicate that the average cost per patient in 1976 was $66—quite a familiar figure to those of you acquainted with the results of the Westinghouse Study which gave average cost per patient in 1971 as $66.

As you can see from Table 10, there is a very little difference in the average cost per patient or per visit between metro and nonmetro areas. It is worth noting that the median cost per patient is about the same as the average cost per patient. In other words, half of the metropolitan programs have a cost per patient of $65 or less, and half of the nonmetropolitan programs have a cost per patient of $64 or less. It is also of considerable interest that the average number of visits in nonmetro programs is 1.9 compared to 1.8 in metro areas—very little difference.

As I mentioned earlier, we felt the reliability of cost data collected with a mailed survey might be limited due to nonresponse and estimating. We submitted these data to detailed analyses in order to see if there might be any systematic underreporting tending to bias the results. To the best of our knowledge, this does not appear to be the case. In particular, Planned Parenthood affiliates—agencies generally believed to maintain more reliable data on costs—do not show patterns which are very different from those of other types of agencies. A smaller unpublished cost study done by AGI in 1976 also found no differences in cost per patient between metro and nonmetro programs.[2]

In an effort to get at the reasons behind these findings, agencies were classified into three groups—those with low costs (under $55 per patient), those with medium costs (between $55 and $99), and those with high costs ($100 or more per patient). Table 11 shows the distribution of metropolitan and nonmetropolitan agencies, by cost and agency type; it also shows the average cost per patient for each of the cost categories. Where sample size is indicated as small, though, be sure to regard the data cautiously.

From the table it would appear that:

- A higher proportion of nonmetro agencies have costs per patient below $55 than do metropolitan providers. More than one-half of nonmetro health departments reported low costs, including in-kind contributions.
- Among medium cost programs, the average cost per patient seems to be slightly lower in metro agencies. The majority of Planned Parenthood affiliates fit into this medium cost range.
- Major differences are apparent in the high-cost group. While about one-fifth of agencies in both metro and nonmetro areas have costs above $100 per patient, the average cost in this group is much greater among the nonmetropolitan programs—$205 per patient compared with $132 in metro programs. While the sample was small, it is interesting to note that the nonmetropolitan health departments in this group show much higher costs than any agencies. Also, "other agencies" are much more likely to fall into the high cost category.

From these data, we can surmise that:

- The nonmetro delivery network includes a higher proportion of low-cost agencies than the metro system.

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[2] A. Torres, unpublished data from AGI, 1976.

- The system also includes some exceedingly high cost programs which must operate under very special conditions.
- When the average cost per patient is calculated, these two extremes tend to cancel each other out, resulting in similar cost per patient for metro and nonmetro areas.

The data in Table 11 also show the cost per patient by type of operating agency. Cost per patient appears to be lower in nonmetro health department programs than in nonmetro Planned Parenthood affiliates and "other agencies," a pattern similar to the findings of the Westinghouse Cost Study. It is important to keep in mind, however, that considerable volunteer time may be included in Planned Parenthood costs.

At the outset of this study, we assumed that a number of agency characteristics would influence costs. Table 12 presents characteristics and average costs per patient related to agency type.

The first characteristic we considered was age of agency. The period when the agency started appears to have little impact on cost in nonmetro areas, unlike metropolitan areas where younger programs apparently cost more.

We also thought that multi-state and multi-county agencies would have a lower cost per patient. We assumed that larger, more complex agencies would show the results of "economies of scale" from centralized activities such as accounting, record-keeping or purchasing. As you can see in Table 12, there is a slight difference in cost per patient between single- and multi-site programs, and in single- and multi-county programs in nonmetro areas, but these differences are also not significant.

Another set of hypotheses concerned differences between organized clinic and physician referral programs. These two models of service are differentiated primarily by the way in which they provide the medical component of family planning service. In the organized clinic, medical examinations and prescriptions of contraceptive method occur at the agency's site. In the typical nonmetro physician referral program, the agency sends a patient to a private physician who provides the medical component of family planning care in his/her private office and is reimbursed by the family planning agency.

As we expected, the data indicate a higher cost per patient in the physician referral programs—$100 compared to an average of $61 per patient in organized clinics in nonmetro areas.

Although the number of physician referral programs responding to the survey was quite small, we should note that this average cost per patient is in line with the costs of physician referral programs which AGI has observed in detailed studies for Indiana and New Hampshire.

Overall, the average costs of clinic programs which do not include any private physician referral component in metropolitan and nonmetropolitan areas are similar—$61 per patient for nonmetro clinics and $69 for metro areas. This similarity in cost per patient is particularly interesting, since it suggests that it is *not* necessarily more expensive to serve a nonmetropolitan patient through an organized clinic service.

If these factors we've just reviewed do not seem to influence clinic costs in nonmetropolitan areas, which characteristics do? Two factors appear to have an effect—size of program operations and distribution of the agency's budget among activities. The impact of size of caseload on program costs appears considerable. As you can see in Table 12, agencies in both areas show a general pattern of declining cost per patient as caseloads increase.

Very small nonmetropolitan programs cost, on the average, $119 per patient, while medium size programs have costs almost one-third that amount; programs with over 5,000 patients in nonmetro areas, however, appear to be more costly.

Total cost of service is another measure of the size of a program's activities. This variable does not indicate the same pattern of declining cost with increased size as we saw when we looked at size of caseload. However, very large programs with high budgets (those with more than $400,000) tend to have a higher cost per patient.

These data suggest that there may be a "break-even" point, whereas size of caseload increases, costs per patient start to go down until the program gets to be really large; and then costs go up. While we cannot determine at this point precisely where that optimum patient load is for nonmetro agencies, it seems to lie somewhere between 1,500 and 5,000 patients.

As I mentioned, the other factor which seems to influence cost per patient is the distribution of an agency's total cost among various program activity areas. We looked at two aspects of cost distribution: the proportion of budget which an agency spends on administration and the proportion spent on medical contraceptive services. These measures are at best rough since we had to rely on the respondents' capacity to report accurately on the distribution of costs by activity. However, as I stated previously, the responses were carefully reviewed, and we feel that the results are reasonable for studying trends and differences.

For all family planning agencies in 1976, Table 13 shows that 26 percent of the budget was used for administration and 55 percent for medical contraceptive services. Nonmetropolitan agencies seem to spend a slightly lower proportion of total cost on administration and a slightly higher proportion on medical contraceptive services than do metropolitan.

The Westinghouse Cost Study found that, in 1971, the average agency spent 32 percent of cost on administration. Allowing for differences between this study and Westinghouse, the data suggest that, during the past several years, family planning providers have reduced the percent of their costs spent on administration.[3] When one considers the events of these years—including inflated costs for personnel, supplies and other support services while Title X funds remained static, such findings are surprising.

It would be useful to know which agency characteristics affect the allocation of resources to administration or to medical contraceptive services. Table 14 relates and shows the percent of budgets spent on these activities to the same agency characteristics we looked at when we discussed cost per patient. (Again, note that this discussion is based on a comparatively small number of respondents in each cell of the table.)

Age of agency appears to have a relationship to the distribution of costs among activities in nonmetropolitan agencies.

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[3] Westinghouse was an on-site study; this study was done by mail. Also, definitions of administration may not be the same.

Younger nonmetro agencies spend, on average, a much higher proportion of budget on administration—35 percent compared to well under 20 percent for medium and old nonmetropolitan providers. They also spend a lower proportion on medical contraceptive service—42 percent of the budget. Since young agencies in this study include all those established between 1970 and 1975, the higher proportion of cost accounted for by administration is unlikely to be merely the result of expenditures for initial start-up of programs. Rather, it may reflect the high cost of outreach conducted more extensively by new agencies in new areas during the early years of their programs.

Once again, the hypothesis that multi-site and multi-county agencies would be more cost-efficient is not borne out; there is no significant difference in proportion of budget allocated to administration in nonmetro agencies between single- and multi-site or single- and multi-county agencies—but they apparently use a higher proportion of their budgets for contraceptive services.

Considering physician referral and clinic programs, the physician referral programs spent a lower percent of their budgets on administration and a higher percent on contraceptive service than did the organized clinic services, but remember that their costs were appreciably higher.

As was the case when we looked at cost per patient, there seems to be a relationship between size of patient caseload and distribution of cost activity. The nonmetropolitan programs with more than 1,500 patients spent a lower proportion on administration and a higher proportion of budget on contraception than smaller nonmetro agencies. This suggests that, in terms of reducing administrative costs, the "break-even" point is also at least 1,500 patients.

Finally, the amount of total resources available to an agency does not seem to have a relationship to allocation of costs among activities. The nonmetro agencies with larger budgets spend a slightly lower percentage on administration; but this difference is minimal.

Summary and Implications

I have presented only a small portion of the results of our evaluation study today. We have a wealth of data from 256 heroic agencies who participated in the study. These data will be further analyzed and presented in a final report. In addition to the kinds of analyses presented here for agencies, we will also be looking at clinic-level performance to determine whether staffing patterns, scheduling, outreach programs and other activities make a difference in program efficiency.

Thus far, we have described the characteristics of the nonmetropolitan family planning delivery network and highlighted some of the differences between metro and nonmetro agencies. Clearly, the delivery networks are different. The metropolitan system has a mix of provider agencies with sizable patient caseloads and large budgets drawn from a variety of sources. In contrast, the nonmetropolitan system is dominated by local health departments which tend to be the sole provider of services in their area. These agencies are likely to have small patient caseloads and are more dependent on project grant funds—most of which they receive through the state health department.

Interestingly, these systematic differences seem to have little impact on costs of service provision. The average cost of family planning services in 1976 was $66 per patient—with virtually *no* difference between metropolitan and nonmetropolitan areas. When we looked at the various agency characteristics, only one—size of patient caseload—had a significant relationship to efficiency. Up to a point, nonmetro agencies with larger caseloads averaged lower costs per patient. But programs with *more* than 5,000 patients and/or *more* than $400,000 budgets appeared to be less efficient.

This study, then, seems to refute some of the "myths" surrounding nonmetro service provision. One is the myth of cost—it simply does *not* appear that nonmetropolitan services must cost more. There are many agencies in nonmetropolitan areas which do just as well with the resources available to them as those in metropolitan centers.

As we saw, the average cost per patient in nonmetropolitan programs which offer clinic services *only* is $61—and there is again little difference between metro and nonmetro services. We might ask, "Why is it generally said that clinics *are* more expensive methods of providing service in rural areas? Are there important benefits of the physician referral model which would argue for its use, despite the cost? Is there an optimum caseload size and/or optimum budget size which assures adequate patient care and efficient management? And how can the efficiency of larger programs be reconciled with the patterns of geographic distribution of the women in need and the bureaucratic regulations of the family planning provider agencies?"

You will recall that the least successful counties were those with only one provider—how can the mix of agencies in nonmetropolitan areas be broadened?

In the tradition of social research, we may, as a result of our findings to date, have raised more questions than we have answered.

In trying to answer these questions, what are the realities we must confront in order to bring services to rural areas? As you can see from the factbook, more than half of all nonmetropolitan counties have fewer than 1,000 low- and marginal-income women in need.

One of the major issues of program development in rural areas is how to improve and expand services in these small counties. As I mentioned earlier, the typical provider in many of these areas is a local health department serving fewer than 500 patients—often with very high costs. One approach to increasing caseloads among these agencies would be to expand their catchment areas, thereby expanding service provision and reducing cost at the same time. This could be accomplished if local health departments, which commonly serve politically-defined jurisdictions—were joined into regionalized networks. State health departments, which already play a considerable role in funding nonmetropolitan services, would have to encourage and support such efforts.

In considering the needs of rural areas, we cannot ignore the 541 nonmetro counties which currently have no organized source of family planning care. This study suggests some approaches that might be useful in developing services for these areas. First, given the findings on costs, it would be logical to start with areas where a caseload of at least 500 patients could rapidly be developed. In 1975, there were 229 nonmetropolitan counties with more than 500 low- and marginal-income women in need and no identified organized service—seemingly prime candidates for service initiation.

Development of new services also requires an operating or sponsoring agency and, in many of these counties, there is likely to be no available local sponsor. In such cases, consideration could be given to development of satellite services from metropolitan-based agencies. Although there are comparatively few such agencies in the U.S. today, these programs do tend to have quite large caseloads—and the same average cost per patient as other providers of service. They are typically Planned Parenthood affiliates.

The unmentionable item in this report has been the hospitals. Given the fact that small community hospitals exist in most nonmetropolitan counties, their invisibility in the family planning delivery network in rural areas is particularly noteworthy. In many counties with smaller numbers of women in need, hospitals could fill the void—or could be used as access points in larger regional programs.

These are just a few of the issues for program development which these data have raised in our minds. And they are questions for which there are probably no easy answers. This afternoon and tomorrow, we'll be hearing from a number of people who have had experience in trying to cope with these and similar programs—working on the local level, in regional programs and from the vantage point of state and federal agencies. We hope that their perceptions—and these study results—will help all of us to think through new—or better—ways of providing family planning services to rural Americans.

NOTE: Deborah Lewis was largely responsible for the design and implementation of this study while other members of the staff of the Planning Unit of The Alan Guttmacher Institute contributed to the collection and editing of these data and preparation of this report.

PRELIMINARY TABULATIONS FROM RURAL EVALUATION STUDY

Tables 1-14

Table 1. Survey response rates, metropolitan and nonmetropolitan samples.

	Total Agencies Surveyed	Usable Responses Number	Usable Responses Percent of Agencies Surveyed	Percent of Desired Response*
Metropolitan Agencies	391	143	37%	73%
Hospital	99	24	24%	48%
Health Department	100	40	40%	80%
Planned Parenthood	96	56	58%	117%
Other	96	23	24%	48%
Nonmetropolitan Agencies	293	113	39%	77%
Hospital	49	6	12%	25%
Health Department	100	39	39%	78%
Planned Parenthood	47	28	60%	117%
Other	97	40	41%	83%

*Desired response equals half of agencies surveyed.

Note: "Other Agencies" include community action agencies, neighborhood health centers, women's clinics, free clinics, health maintenance organizations and specifically incorporated family planning agencies.

Table 2. Comparison of the universe and the survey sample.

A. By three metropolitan area designations

	Universe		Weighted Sample		Unweighted Respondents	
	Number	Percent	Number	Percent	Number	Percent
Total	2,516	100	2,516	100	256	100
Metropolitan	1,049	42	1,049	42	143	56
Nonmetropolitan	1,467	58	1,467	58	113	44
Nonmetropolitan Based	1,403	56	1,426	57	98	38
Metropolitan with Nonmetropolitan Sites	64	2	41	1	15	6
Percent of Nonmetropolitan Total which are Metropolitan based		4		3		13

B. By single-site/multi-site agency status

	Universe		Weighted Sample		Actual Respondents	
	Number	Percent	Number	Percent	Number	Percent
Total	2,516	100	2,516	100	256	100
Single-Site	1,763	70	2,051	82	176	69
Multi-Site	753	30	465	18	80	31
Metropolitan	1,049	100	1,049	100	143	100
Single-Site	721	69	794	76	96	67
Multi-Site	328	31	255	24	47	33
Nonmetropolitan	1,467	100	1,467	100	113	100
Single-Site	1,042	71	1,257	86	80	71
Multi-Site	425	29	210	14	33	29

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Table 3. Summary statistics—all agencies.

Variable	Number of Responses		Statistics for Weighted Data			
	Actual	Weighted	Minimum/ Maximum	Median	Mean	Standard Deviation
Age of Agency (year established)	231	2,164	1926-1975	1,968.1	1,966.8	7.2
Number of Sites	256	2,516	1-38	1.6	1.7	2.2
Number of Counties	255	2,487	1-28	1.5	1.2	1.1
1976 Total Patients	256	2,516	30-36,573	635.0	1,757.0	3,215.5
1976 Total Visits	239	2,302	55-70,043	1,214.0	3,189.0	5,653.6
Percent Patients <$5,000 Income	231	2,320	0%-100%	54.5%	53.7%	26.2%
Percent Patients >$10,000 Income	229	2,300	0%-59%	1.6%	4.6%	7.1%
Percent 1975 Patients Retained	225	2,086	2.3%-100.0%	62.5%	62.6%	20.5%
Percent of Patients in Area Served by Sample Agency	256	2,516	0.3%-100.0%	85.2%	65.5%	39.1%
Number of Low- and Marginal-Income Women in Need	256	2,516	397-377,962	3,573.0	26,215.0	65,096.7
Visits Per Patient	239	2,302	1.04-5.67	1.66	1.83	0.70
Total Cost	184	1,417	$1,822-4,960,000	$82,500	$168,935	$305,750
Program Cost Per Patient	184	1,417	$15.92-$436.67	$64.41	$86.74	$78.39
Program Cost Per Visit	178	1,353	$11.17-$200.19	$39.01	$45.36	$28.97
Percent Cost Administration	172	1,270	1%-80%	20.5%	25.9%	17.9%
Percent Cost Contraception	173	1,298	1%-96%	58.8%	55.5%	21.5%
DHEW Grant Funds*	167	1,247	$550-873,835	$25,917*	$ 79,977*	$109,988
Percent of Budget—DHEW*	156	1,064	0.7%-100.0%	63.8%	62.4%	26.1%
State Health Department Funds*	56	600	$827-250,000	$15,144*	$ 28,644*	$ 40,877
Percent of Budget—State*	48	461	0.8%-100.0%	46.4%	53.3%	37.3%
Title XIX Funds*	147	1,009	$100-926,000	$ 5,950	$ 17,936*	$ 52,811
Percent of Budget-XIX*	144	975	0.1%-49.7%	6.1%	9.2%	9.1%
Title XX Funds*	83	618	$100-800,000	$15,806	$ 15,469	$120,901
Percent of Budget—XX*	82	605	0.1%-99.7%	19.8%	25.8%	25.5%
Patient Fees*	132	695	$ 63-874,000	$ 7,260	$ 34,253	$ 87,271*
Percent of Budget—Patient Fees*	131	683	0.1%-99.7%	8.1%	13.4%	16.1%

*Statistics include only those agencies with funds from source.
All statistics exclude unknowns.

Table 4. Standard error of percentages of agencies, by type of agency and metropolitan status.

	Size of Universe	Size of Sample	Percentage					
			5 or 95	10 or 90	20 or 80	30 or 70	40 or 60	50
Metropolitan								
Hospital	289	24	4.3	5.9	7.8	9.0	9.6	9.8
Health Department	352	40	3.2	4.5	6.0	6.8	7.3	7.5
Planned Parenthood	117	56	2.1	2.9	3.9	4.4	4.7	4.8
Other	291	23	4.4	6.0	8.0	9.2	9.8	10.0
Total Metropolitan	1,049	143	2.0	2.8	3.7	4.3	4.5	4.6
Nonmetropolitan								
Hospital	58	6	8.5	11.7	15.6	17.9	19.1	19.5
Health Department	1,122	39	3.4	4.7	6.3	7.2	7.7	7.9
Planned Parenthood	54	28	2.9	4.0	5.3	6.1	6.5	6.6
Other	233	40	3.1	4.3	5.8	6.6	7.1	7.2
Total Nonmetropolitan	1,467	113	2.7	3.7	4.9	5.7	6.0	6.2

Note: These standard errors of percentages can be used to compute 95 percent confidence intervals of percentages. If the confidence intervals of two percentages do not overlap, the two percentages are significantly different. If the confidence intervals do overlap, one cannot infer that the two percentages are significantly different.

Ex. Sample of metropolitan agencies has 30 percent and sample of nonmetropolitan agencies has 50 percent with a characteristic.

The 95 percent confidence intervals are

30 ± 2 (4.3) = 30 ± 8.6 or 21.4 to 38.6

and 50 ± 2 (6.2) = 50 ± 12.4 or 37.6 to 62.4.

Since the two confidence intervals overlap, one cannot infer that the 30 percent and 50 percent are significantly different at the 95 percent confidence level.

Table 5. Distribution of provider agencies by metropolitan status.

Metropolitan Status	Percent of Agencies		
	Total	Single Provider in Area	Provider in Multi-Agency Area
Metropolitan	100	18	82
Nonmetropolitan	100	63	37
Total	100	44	56

Figure A. Summary of characteristics of agencies serving nonmetropolitan and metropolitan areas.

Characteristics	Metropolitan	Nonmetropolitan
	All Agencies	
Age of agency	60 percent of agencies established pre-1970	61 percent of agencies established pre-1970
Number of sites	31 percent operate more than one site; median number of sites for multi-site agencies—4.6	29 percent operate more than one site; median number of sites for multi-site agencies—3.8
Number of counties covered	98 percent single-county; average number of counties covered by multi-county—2.5	92 percent single-county; average number of counties covered by multi-county—4.6
Size of caseload	14 percent serve less than 500 patients; 17 percent serve more than 5,000 patients	56 percent serve less than 500 patients
Income distribution of patients	27 percent have no patients with incomes above $10,000	47 percent have no patients with incomes above $10,000
	Health Departments	
Role in system	34 percent of all provider agencies	76 percent of all provider agencies
Age of agency	80 percent operating pre-1970	66 percent operating pre-1970
Number of sites	50 percent operating more than one site	23 percent operating more than one site
Number of counties covered	99-100 percent single county	95 percent single county
Program type	Clinic	Clinic and referral
Size of caseload	10 percent serve less than 500 patients; 22 percent serve more than 5,000 patients	65 percent serve less than 500 patients
Income distribution of patients	31 percent have no patients with incomes above $10,000	53 percent have no patients with incomes above $10,000
	Planned Parenthood	
Role in system	11 percent of all agencies	Four percent of all agencies
Age of agency	50 percent operating pre-1965	31 percent operating pre-1965; 50 percent of agencies only in nonmetropolitan areas established 1970-75
Number of sites	61 percent operate more than one site	83 percent operate more than one site
Number of counties covered	14 percent have sites in more than one county	69 percent have sites in more than one county
Program type	Clinic	Clinic and referral
Size of caseload	None serve less than 500 patients; 43 percent serve more than 5,000 patients	Less than one percent serve fewer than 500 patients; 39 percent serve more than 5,000 patients
Income distribution of patients	Four percent have no patients with incomes above $10,000	Eight percent have no patients with incomes above $10,000
	Other Agencies	
Role in system	28 percent of total agencies	15 percent of total agencies
Age of agency	85 percent established 1970-75	73 percent established 1970-75
Number of sites	18 percent operate more than one site	46 percent operate more than one site
Number of counties covered	85 percent single county	99-100 percent single county
Program type	Clinics and referral	Clinics and referral
Size of caseload	22 percent serve less than 500 patients; five percent serve more than 5,000 patients	25 percent serve less than 500 patients; 33 percent serve more than 1,500 patients
Income distribution of patients	29 percent have no patients with incomes above $10,000	38 percent have no patients with incomes above $10,000

Note: Data on multi-site agencies from count of universe; all other data based on study sample.

Table 6. Distribution of provider agencies by women in need and metropolitan status.

Women in Need in Area	Percent of Agencies and Metropolitan Status					
	Metropolitan			Nonmetropolitan		
	Total	Single Provider in Area	Provider in Multi-Agency Area	Total	Single Provider in Area	Provider in Multi-Agency Area
<1,000	—	—	—	33	42	19
1,000-2,499	5	22	1*	32	36	26
2,500-4,999	11	37	5	25	19	34
5,000-19,999	34	40	33	10	4	20
20,000 +	50	1*	61	1*	—	1*
Total	100	100	100	100	100	100

* Data considered to be unreliable due to small sample size, i.e., less than 10 respondents.

—No respondents in cell.

Percents may not total to 100 due to rounding.

Table 7. Distribution of provider agencies by percent of women in need served in the area and metropolitan status.

Women in Need Served in Area	Percent of Agencies and Metropolitan Status					
	Metropolitan			Nonmetropolitan		
	Total	Single Provider in Area	Provider in Multi-Agency Area	Total	Single Provider in Area	Provider in Multi-Agency Area
Low (<25%)	22	51	16	44	52	29
Medium (25-39%)	42	14	47	32	27	40
High (40-95%)	36	35	36	24	9	31
Total	100	100	100	100	100	100

Percents may not total to 100 due to rounding.

Table 8. Distribution of metropolitan and nonmetropolitan agencies by total cost.

Metropolitan Status	Median Program	Percent of Agencies				
		Total	<$75,000	$75,000-149,999	$150,000-399,999	>$400,000
Total	$ 82,500	100	46	25	20	9
Metropolitan agencies	153,500	100	16	28	36	20
Nonmetropolitan agencies	43,500	100	70	23	6	2
Agencies only in nonmetropolitan areas	**	100	74	22	3	(a)
Metropolitan-based with nonmetropolitan sites	**	100	14	5	43	36

(a) Less than one percent.

** Cannot be calculated from currently-available data.

Table 9. Average and median funds received from major sources by metropolitan and nonmetropolitan agencies (based only on those receiving funds).

Source of Funds	Percent of Agencies Receiving Any Funds		Average Percent of Budget Received[1]		Average Funds Received		Median Funds Received	
	Metropolitan	Nonmetropolitan	Metropolitan	Nonmetropolitan	Metropolitan	Nonmetropolitan	Metropolitan	Nonmetropolitan
DHEW Title X/V	77%	69%	59%	65%	$110,100	$54,400	$73,400	$31,200
State Health Department	28%	43%	36%	62%	$ 49,300	$18,300	$19,800	$12,000
Title XIX	72%	63%	11%	7%	$ 30,100	$ 7,200	$ 8,400	$ 2,900
Title XX	40%	40%	29%	24%	$ 82,800	$29,600	$25,300	$13,400
Patient Fees	54%	35%	14%	13%	$ 42,400	$25,000	$ 9,000	$ 6,800

[1] Since different agencies use different sources of funds, percents of budget do not add to 100 percent.

Table 10. Summary measures of cost of service provision, metropolitan and nonmetropolitan agencies.

Measure of Cost	Total	Metropolitan Agencies	All Nonmetropolitan Agencies	Agencies Only in Nonmetropolitan Areas	Metropolitan-Based Agencies with Nonmetropolitan Sites
Average cost per patient	$66	$67	$63	$62	$65
Median program cost per patient	64	65	64	**	**
Average cost per visit	39	40	35	33	40
Median program cost per patient	39	38	41	**	**

**Cannot be calculated from currently available data.

Table 11. Distribution of agencies by cost per patient and type of agency.

Cost per Patient	All Agencies		Hospitals		Health Departments		Planned Parenthood		Other	
	Percent	Average Cost per Patient	Percent	Average Cost per Patient	Percent	Average Cost per Patient	Percent	Average Cost per Patient	Percent	Average Cost per Patient
Metropolitan Only	100	$ 67	100*	$ 60*	100	$ 67	100	$ 72	100	$ 70
Low (<$55)	31	42	27*	46*	39	41*	29	47	27	34*
Medium ($55-99)	47	67	64*	65*	48	68	60	66	27	74*
High (>$100)	22	132	9*	. . .	13	113*	11	144*	47	130*
Nonmetropolitan Only	100	$ 62	100	—	100	$ 58	100	$ 72	100	$ 65
Low (<$55)	48	41	—	—	55	39	33	46*	32	45
Medium ($55-99)	31	78	—	—	28	73*	53	85*	32	78
High (>$100)	21	205	—	—	17	282*	13	134*	35	153
Metropolitan with Nonmetropolitan Sites	100	$ 65	—	—	—	—	100*	$ 61	100*	$ 82*
Low (<$55)	24	46	—	—	—	—	42*	46*	—	—
Medium ($55-99)	76	76	—	—	—	—	58*	73*	100*	82*
High (>$100)	—	—	—	—	—	—	—	—	—	—

*Data considered unreliable, due to small sample size; i.e., less than 15 respondents in the denominator of a distribution of less than 10 respondents for calculating average cost.

. . . Only one agency responded.

—No respondent in cell.

Table 12. Average cost per patient by characteristics of agencies in metropolitan and nonmetropolitan areas.

Characteristic of Agency	Total Agencies	Metropolitan Agencies	Agencies Only in Nonmetropolitan Areas	Metropolitan-Based Agencies with Nonmetropolitan Site
Average Cost Per Patient	$ 66	$ 67	$ 62	$ 65
Agency Age				
Old (1926-1964)	$ 64	$ 67	$ 65	$ 55*
Medium (1965-1969)	63	63	62	79*
Young (1970-1975)	73	76	62	79*
Number of Sites				
Single Site	$ 65	$ 65	$ 64	N.A.
Multi-Site	67	69	58	65
Number of Counties Covered				
Single County	$ 65	$ 65	$ 64	N.A.
Multi-County	71	93*	59	65
Type of Program				
Clinic Only	$ 67	$ 69	$ 61	$ 60
Physician Referral Only	100*	—	100*	—
Clinic and Physician Referral	57*	. . .	178*	74*
Size of Caseload				
<500 Patients	$126	$167*	$119	—
500-1,499 Patients	77	83	72	78*
1,500-4,999 Patients	60	69	43	78*
5,000 + Patients	64	64	77	64*
Total Cost of Service				
<$75,000	$ 64	$ 70	$ 62	$ 75*
$75,000-149,999	56	52	61	85*
$150,000-399,999	63	63	60*	61*
$400,000 +	73	74	97*	66*

*Data considered to be unreliable, due to small sample size; ie., less than 10 respondents.

. . . Only one agency responded.

N.A. Not Applicable.

—No respondents in cell.

Table 13. Percent of cost allocated to administration and medical contraceptive service, by cost per patient and metropolitan status.

Cost per Patient	Total	Metropolitan Agencies	Agencies Only in Nonmetropolitan Areas	Metropolitan-based Agencies with Nonmetropolitan Sites
A. Average Proportion of Cost for Administration				
Total	26	29	23	23
Low (<$55)	22	29	17	25*
Medium ($55-99)	28	28	30	21*
High (>$100)	24	25	23	—
B. Average Proportion of Cost for Medical Contraceptive Service				
Total	55	52	59	58
Low (<$55)	64	57	69	54*
Medium ($55-99)	53	53	52	59*
High (>$100)	51	50	52	—

*Data considered to be unreliable due to small sample size; i.e., less than 10 respondents.

—No respondent in cell.

Table 14. Average proportion of budget allocated to administration and to medical contraceptive service.

	Total Agencies		Metropolitan Agencies		Agencies Only in Nonmetropolitan Areas		Metropolitan-Based Agencies with Nonmetropolitan Site	
Characteristic of Agency	Percent on Administration	Percent on Contraception	Percent on Administration	Percent on Contraception	Percent on Administration	Percent on Contraception	Percent on Administration	Percent on Contraception
Average Proportion of Budget	26	55	29	52	23	59	23	58
Agency Age								
Old (1926-1964)	25	56	29	50	18*	66*	23*	60*
Medium (1965-1969)	22	65	31	54	14	74	25*	46*
Young (1970-1975)	31	47	28	50	35	42	21*	63*
Number of Sites								
Single Site	26	55	30	51	23	58	N.A.	N.A.
Multi-Site	25	58	25	54	24	67	23	58
Number of Counties Covered								
Single County	26	55	29	52	23	58	N.A.	N.A.
Multi-County	22	59	24*	53*	21	63	23	58
Type of Program								
Clinic Only	27	54	30	50	24	57	27*	40*
Physician Referral Only	17*	67*	—	—	17*	67*	—	—
Clinic and Physician Referral	25*	51*	. . .	. . .	31*	30*	. . .	. . .
Size of Caseload								
<500 Patients	25	56	37*	53*	23	57	—	—
500-1,499 Patients	26	56	25	55	28	56	17*	72*
1,500-4,999 Patients	25	55	30	49	15	69	28*	50*
5,000+ Patients	27	54	27	54	16*	66*	24*	54*
Total Cost of Service								
<$75,000	24	60	30	54	23	61	. . .	. . .
$75,000-149,999	26	56	31	51	21	62	. . .	. . .
$150,000-399,999	25	56	28	56	19*	53*	25*	51*
$400,000+	22	51	22	50	. . .	. . .	23*	55*

*Data considered to be unreliable, due to small sample size; i.e., less than 10 respondents.

. . . Only one agency responded.

N.A. Not Applicable. Metropolitan-based agencies with nonmetropolitan site are multi-site and multi-county by definition.

— No respondents in cell.

Family Planning Services in Rural America: Some Implications For Programs and Policies

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Introduction

The national family planning program must be acknowledged as one of the most successful, most cost-effective, most needed and most studied federal programs in the U.S. today. With roots extending back to the beginning of the century, but with growth largely limited to the last 10 years, the program has achieved almost singular success in terms of goal-oriented accomplishments among the various federally-financed health care efforts.

Studies and papers and conferences and reports have documented the progress of the field. We collectively serve nearly four million persons annually with comprehensive fertility management and related health services. By the year 1973, more than nine in 10 persons who were potential users of contraception employed some means to prevent or postpone pregnancy, and increasingly contraceptors are using the most effective means of birth planning. It has been estimated that between 1970 and 1975, the organized program helped low- and marginal-income persons postpone or prevent in excess of one million births, and that the expenditure of one public dollar for family planning care returns a public savings of nearly twice that amount within a year—a short-term cost/benefit ratio unmatched in any other public program.

Our collective knowledge of the delivery system, the services it provides and the patients it serves is fairly extensive. Thanks to the financial support of both governmental and private organizations and to the research skills of agencies such as The Alan Guttmacher Institute, we are able to identify over 2,500 agencies operating 5,000 clinic sites in 80 percent of all U.S. counties. We know that more than half of all patients had incomes at or below the official poverty level and that nearly nine in 10 were below 200 percent of that level. We know that more than half of all patients are in their twenties, and that nearly three-fourths had either one child or no children.

Indeed, a very great deal is known about the national program. This Conference and this new Guttmacher Institute study provides us with even more knowledge—some of it surprising.

The Surprises

Two major findings of the study relate to money—to the average cost per patient served throughout the composite delivery system. First is the finding that the national program was able to serve the average patient in 1976 for the sum of $66. This is an astounding accomplishment when compared to the nearly identical per patient cost experienced half a decade ago. In spite of double-digit annual inflation, in spite of dramatic increases in the cost of energy and petroleum-based medical and clinical supplies, in spite of reams of newly added and time-consuming reports to the federal government, in spite of rising malpractice insurance premiums, in spite of added services and even postage stamps which now cost about two-thirds more than they did in 1971-72, average family planning costs remain the same. What other public programs can make that statement?

Second is the finding that the often discussed cost differential between rural and metropolitan area programs is, in reality, insignificant. What differential does exist actually shows the average cost *and* the median cost for rural services to be somewhat less than corresponding figures for per patient costs in metropolitan areas.

While these findings should attract the interest of the Department of Health, Education and Welfare, I am not certain they can attract that interest with equal degrees of reliability. Certainly the national per patient average cost is reliable insofar as it reinforces and supports earlier data. We must look at the rural-urban cost figures with greater scrutiny, however, since they are based upon 1976—and 1976 was an unusual year for rural family planning services.

Recall that late in calendar 1975, President Ford reduced national family planning funding available through Title X by approximately 21 percent. This multi-million dollar cutback was felt by the various programs in 1976 with the result that many smaller programs, many rural programs, many less efficient programs were closed. These actions, particularly as they related to nonmetropolitan programs, may well have had the effect of making rural services appear to be less costly in this study than they were a year earlier or will be a year from now. This finding therefore bears additional study.

Analysis

Beyond the possible uncertainty of the reliability of this particular finding, however, the study sets forth a picture of the rural family planning delivery system which calls for analysis. The study shows the rural system to be dominated by local health departments. Of *all* provider agencies, both rural and urban, over half are in nonmetro areas. Of those, 75 percent are local health departments—small local health departments—serving mainly a single county and seeing fewer than 500 patients annually. In fact, better than eight in 10 single county rural programs are operated by such departments, and in 90 percent of those cases, the health department is the *only* organized provider of family planning care in the county.

It is important to sense this rural delivery system with some degree of depth prior to discussing implications of this study for both programs and policy. It is in part against the existing delivery system and against any rural-urban differences that program changes, if appropriate, must be made and that policy decisions must be considered.

The rural system, or perhaps more accurately the local health department system, is largely traditional—single site, single county programs serving small patient caseloads. Cost per patient generally appears to be slightly below the national average. One could easily propose that expansion of services in rural America could best be achieved through the local health department system.

But that isn't all of the data. A smaller number of rural programs are operated by Planned Parenthood affiliates, community action agencies, neighborhood health centers and others. What of these delivery mechanisms? Planned Parenthood programs are more generally multi-county in orientation and generally have three to four and one-half times the patient caseload—but at slightly greater per patient costs. Neighborhood health centers, in spite of discussion within the Bureau of Community Health Services, are not a viable partner since they represent only three percent of provider agencies. Community Action Agencies, while often limited geographically, do represent reasonable costs and add significantly to the overall delivery system's capability. What roles might these parts of the system play in a national effort to expand services?

Stepping back and looking at the entire national system, rural and urban, provides another interesting vantage point. Of *all* provider agencies, 55 percent are health departments, and they collectively serve 44 percent of all patients. Hospitals account for over one-fifth of the providers, but serve only 14 percent of the patients. Planned Parenthood affiliates represent a small proportion of providers but serve one-fourth of all patients. All other providers combined serve the remaining 16 percent.

In metropolitan programs, a better "mix" of provider agencies exists; there are almost no monopolies in the cities. And caseloads of all are generally on the increase. Is this useful information as we look to rural expansion?

Implications

With these additional pieces of information on hand, it is possible to better address program and policy implications. But first, one last factor of the rural-urban picture must be acknowledged. Who hasn't fervently believed that rural areas are "more conservative?" That rural attitudes and values make work more difficult in family planning programs? To some degree, rural America *has* been "conservative," but what about today? The anti-ERA battles, the anti-abortion battles, the anti-gun control battles—where are they being staged and orchestrated? The cities. Perhaps the rural-urban distinction is not so much one of conservative-liberal as it is one of conservative and becoming conservative. The day has passed when the nature of delivery system in rural America can be defined on the liberal-conservative axiom.

If we in this country are serious about our desire to enable all persons to voluntarily manage their own reproductive lives, if we are serious about eliminating place of residence as a barrier to service availability, if we are serious about reducing teenage pregnancies, if we are serious about reducing the need for over one million abortions each year, if we are serious about removing financial barriers for the poor, then we have to make some policy level decisions. We have to decide to look at the system we have, build upon the good parts, modify the weak ones and take some new initiatives. We have to decide where to put our money.

The data we have heard tell us there may be no substantial cost-differential in rural as compared to urban services. Then why are we still meeting less proportion of the need for family planning care in rural areas? Perhaps because we allocate more of our resources to urban areas (about 75 percent in 1976). Maybe we ought to rethink that. If we do, we'll have to rethink the delivery system as well.

Is is unlikely single site county health departments in rural America will expand services to the county next door. Political subdivisions generally work against such ideas as do mill-rate limitations on the property tax. In order to expand services to more patients, other providers will have to be offered financial aid. In rural areas, Planned Parenthood affiliates and Community Action Agencies seem to be both logical and efficient ways to help achieve this goal.

We will have to find better ways of cross-utilization of personnel. In Minnesota, public health nurses in the employ of both health departments and private community nursing services, and social workers from local welfare departments, and outreach workers from Planned Parenthood, and counselors from family counseling agencies, and private physicians all lend their talents to one integrated service delivery system. The system runs efficiently and avoids unnecessary duplication of costs.

We will have to re-order our priorities. The Congressional Appropriations Committee just approved an expenditure of nearly half a billion dollars for two airplanes which the President says the military does not need. At 1976 expenditure rates, the money for those two airplanes would operate the *entire* national family planning delivery system for perhaps three years (excluding in-kind financing, of course). At the average cost of $66 per patient, over seven and one-half million people could be cared for with that money.

We will have to make bold and forthright political decisions—decisions which make it possible to reduce teenage pregnancies, to reduce unplanned births to women of all ages, to reduce the need for abortion—especially second trimester abortion, to reduce retardation and disability among infants born to women at the extremes of the reproductive years.

We will have to stop playing games of rhetoric within governmental offices and begin looking at the data and listening. The current emphasis by the Bureau of Community Health Services to promote an ill-defined configuration of community neighborhood health centers as the ultimate family planning delivery mechanism lacks an understanding of reality. Such centers are almost non-existent in rural America, and among clinical programs in urban areas they represent the highest per patient costs of all clinical vehicles—in fact their costs are 35 percent above the average for all urban clinic programs.

We will have to develop additional legislation to increase appropriations for family planning through Title X—the very backbone of this nation's organized program. And we will have to hold Title XX agencies accountable for family planning expenditures. We'll have to find out what Title XIX is doing in family planning because nobody knows now. We will have to return to a universal count national data system to enable the delivery system to maximize all available funds for patient services rather than using those funds to purchase computer printout from a variety of large and small and uncoordinated computers.

We will have to develop means to increase the range and scope of services available through the family planning delivery system to further expand the comprehensive nature of the program, and we will have to use the bulk of the existing delivery system in these efforts if we are to have any chance of reaching the largest number of consumers at the most reasonable costs. Over the last decade we have seen family planning care become an increasingly important component of health care—the only component for some patients. Physical examinations, diagnosis and treatment of minor gynecological disorders and venereal disease, laboratory work for the discovery of anemia and diabetes, screening and regular monitoring for hypertension, nutrition counseling and education, an extensive cross-referral network and the nation's largest organized network for cervical cancer detection *all* already exist within the family planning program. Any attempt to diminish the mix of agencies and the geographic dispersal of this program can only come at the ultimate expense of the consumer. It only makes sense to further develop this system, refine it, improve it, give it realistic financial support to enable it to better serve the basic health-care needs of reproductive-aged individuals.

Conclusion

The family planning program in this country has met remarkable patient acceptance and has established unprecedented achievements in a relatively short time. The rural component of the overall program has not fared quite so well. Today's rural program is overly dependent upon local health departments—agencies which cannot be expected to single-handedly meet existing needs. The rural system is underfunded—in part because of heavy financial allocations to urban areas and in part because the entire national program is underfunded and has been for years. The rural system has been afflicted with too many assumptions—such as exorbitant per patient costs and community non-support—factors which have not been too carefully critiqued.

As a result of this new study by The Alan Guttmacher Institute, and as a result of conferences such as this, perhaps we all can learn something new. Perhaps we all can begin to look at the new initiatives which are needed. Perhaps we can then approach our own programs with a renewed sense of purpose and direction and innovation. And if we continue to succeed in the future as we have in the past, maybe—just maybe—we can encourage the Administration and the Congress to make family planning a national priority. It was at the highest levels of government that the policies and priorities of the "new federalism" were formulated—and some of those policies and priorities nearly destroyed this nation's family planning effort. Their impact upon various rural programs was particularly devastating. It is at those same levels that realistic goals can be set for the future.

The providers and consumers of family planning services have, by and large, been too inactive in providing information and opinion in the formulation of national and state policies. We have through abdication allowed others to act in their own interests.

By way of example, permit me to quote a few lines from another paper:

> . . . President Carter's policy of opposition to federal funding of elective abortion deserves our support, especially in light of the sharp and often unfair attacks directed against it by the pro abortion groups. At the same time, one must hope that the Administration will not proceed to press for massive federally backed family planning programs as an alternative to abortion for these would represent an unprecedented and unacceptable governmental intrusion into family life. . . . A concrete test of the seriousness of our commitment to the basic human right to life is the energy and urgency with which we address ourselves to such matters.

These remarks were delivered by the President of the National Conference of Catholic Bishops to the annual national meeting of the Knights of Columbus in August of this year in Indianapolis. It bears repeating that we have through abdication allowed others to act in their own interests, and that must change!

We have a great deal to look upon with a justifiable sense of accomplishment. We have in place the fundamentals of a national (rural and urban) system to enhance the availability of certain basic health care services at affordable costs. We now must act to not simply preserve that status-quo but to develop it to its yet to be reached fullest potential.

Discussion

QUESTION #1: Did you calculate the proportion of funds that came from county appropriations or from local funds?

DONNA FRIEDMAN: Yes, we have that data, but we haven't shown that in this tabulation.

QUESTION #1: That might be important if local health departments are to expand their programs. I know it's possible to do this. You might look at that particular piece of information not as a barrier but as a benefit. I don't think there's much going in from the local sector, frankly. I would think the taxpayers' attitudes would prevent expansion.

THOMAS WEBBER: It would occur to me that what you have to say may be valid where local health departments have a jurisdictional ability to expand across the county line. After having spent many years working for local health departments, I know how fervently we hold our county boundaries.

JOY DRYFOOS: We are going to have two papers this afternoon which describe a regional health department network in Texas, and I think that there are a number of states, actually, that have regionalized—that is, programs cross county lines.

FREDERICK JAFFE: There are 50 states in this country, and they probably run their health and welfare services in a hundred and fifty ways. In some states it may be possible to move across county lines. In other states it may not be possible. I just don't think there is any flat position one way or another. Certainly, where I live in New York, there is a big flap going on because there is an attempt, through the health planning network and the health systems agencies, to regionalize obstetrical care. And all the hospitals in Westchester County are up in arms, because, in essence, there's a move to cut down on the obstetrical services of some hospitals, put them into several larger ones, and then regionalize a neonatal intensive care unit for about a nine-county area. Now, it's encountering opposition, but it's a process going on in New York State and probably in other states as well. The same kind of process could then spill over into things like local health department family planning services. I just think that you have to look carefully at those developments within your state and get some better fix on whether it's possible to regionalize in some states, while I think in others it's going to be 50 years. There's one state health department where the commissioner, who had been there for about 50 years, recently retired, and I was told that no piece of paper came out of that department unless he personally reviewed it. Well, in that kind of state, I would doubt that you are going to be able to make a lot of progress.

QUESTION #2: I have several comments about various points that were made. The first one is that I'm really concerned and offended by the whole morning's presentation of just a concern about the cost of health care, and not one mention was made about the quality of health care. And to me, as a consumer of health care and as a woman who uses health services, that needs to be a focus of concern, and we haven't talked about that at all. I see excessive concern about what the cost is, whether it's $66 or $69, as a way to close out small clinics that do provide quality health care but may not be the most efficient. Through the process of HSA's, county regulations, federal regulations, small clinics have been regulated out of existence. I am part of a small health clinic that knows that we provide high quality health care services. And yet, through this whole morning's presentation, we are not efficient, and, therefore, the other assumption is that we should not be in existence—because we're not efficient. It's very important that women and men have the option of where to go to get health care and that they be able to choose whether or not they want to go to a big program that may be very cost-efficient, or a small program that may be less cost-efficient but which provides more information, more personalized care.

The second thing that concerned me was what I call the "Archie Bunker" approach to health care—talking about how much it costs the taxpayers. We've seen what effect this has had on abortion. We all know that, yes, it costs less money to pay for an abortion than to pay for maternity care, to pay for childrearing, but that has not been what has happened these past few months. Abortion funds have been cut back, and it's not because it costs less to provide abortion, and they don't care what the cost-effectiveness is. The second thing that goes along with cost-effectiveness is that the thing that really costs the least is sterilization. And I know from other conferences and from information I have been reading that Planned Parenthood and health departments are really actively involved in setting up sterilization clinics all around the country, particularly rural counties, because that is the most cost-effective method of family planning. They are not allowing the other options of women getting birth control, getting abortions. What they are saying is that women need to go to sterilization programs, because that's the only thing that is available. All the money is being put into sterilizations—that money is not being put into abortions.

AUDIENCE PARTICIPANT: Where's your data on that?

QUESTION #2: That money is not going to abortions—they've cut it out.

AUDIENCE PARTICIPANT: No, that's not the same thing. There's no money in sterilizations, either.

QUESTION #2: You may disagree with that, but the fact is that money is not being given for other areas of family planning; it's being put into sterilization. There is a very interesting conference that happened just last week in Syracuse with ACS and Planned Parenthood where they talked about setting up family planning clinics for sterilization. And, OK, I know that I am in inhospitable company where people may not have had as much contact with sterilization abuse, but we know that is going on.

The other point was the last comment about blaming consumers and blaming providers for not being more influential in making policies. Our experience is that when you try to become more influential in making policies, you get stomped on by the people who have the power. It is often the medical association that won't let consumers and small providers become involved in HSAs, because they control the whole organization. So I really resent that kind of attack on consumers and on providers and on women for not being more influential, because when we have tried, we've been stomped on by the medical association that doesn't want our input.

AUDIENCE PARTICIPANT: Anyone making unsupported statement is always . . .

QUESTION #2: That was a supported statement about states that have used money. Virginia is one example that they used at that Conference where all the money was going to sterilization clinics.

FREDERICK JAFFE: OK. Thank you very much. I think that you're wrong about one thing. I don't believe that this is an inhospitable Conference for the concerns of women and women's health. To focus on costs does not mean that nobody is concerned about quality. I think costs and cost issues have to be addressed as well as quality. Most of the federally supported family planning programs that we are talking about, which receive a fairly significant amount of federal money, spend their money on contraceptives. Depending on how you count, these programs get 150 or 160 million federal dollars a year. Very few sterilizations are done in those programs. There are many people in this room who are as concerned as you are with something called sterilization abuse. But perhaps we need to sit down and get some information and agree on some information as to what you mean by sterilization abuse. For the last 10 years this program has made available contraceptive services to large numbers of poor women who didn't have them available before. At the same time there has been a very, very great increase in the voluntary acceptance of sterilization, shown and documented by systematic national studies. So within that context I think that there ought to be an opportunity for people to sit down with different points of view, agree on some facts, and then try to work through toward how we can respectively and jointly remedy some of the concerns that we mutually share.

QUESTION #3: I have a cost containment question. With due respect, I wondered if there are any data to support my hunch (or conviction rather) that the development of the family planning nurse practitioners' movement over the past few years has significantly impacted on cost containment. And secondly, are there data that you have on the impact of these nurse practitioners on expansion, particularly in the rural programs?

DONNA FRIEDMAN: As far as data over the past 10 years go, our study probably wouldn't help you too much, because it is simply a cross-section that was taken of information provided for calendar year 1976. We are about to begin our analysis, however, of the clinic level information that we gathered. One of the primary things about staffing patterns that we asked people to tell us about are the number of nurse practitioners they have, what their nurse practitioners are doing in the program, the amount of time they spend on providing medical service and the time they spent on administrative functions, and I hope, by the Spring, we can answer part of your question. Unfortunately, we can't answer the first one which is probably one of the more important ones we could look at today.

QUESTION #4: Referring to Table 10 and the average cost of patient care, is that "per patient visit" the annual cost?

DONNA FRIEDMAN: This is annual total cost you're looking at, both in the per patient figures and the per visit figures.

QUESTION #4: Since there's about a 20-time higher difference in cost of in-patient as opposed to out-patient care, were tubal ligations—in-hospital patient care—figured into this?

DONNA FRIEDMAN: No, it wasn't. We specifically asked respondents to only include the cost of medical family planning provision excluding sterilization and abortion costs.

QUESTION #4: For what year are these data?

DONNA FRIEDMAN: This is for calendar year 1976.

QUESTION #5: When you're talking about regionalization of health care and blending of health departments, are there any data available that will help us on how far the consumer will travel to get that health care? I think I hear something about having fewer service sites and fewer geographic lines, and it might be appropriate to know what would be the most expeditious thing to do.

FREDERICK JAFFE: There have been some studies in other fields of health care on the relationship between distance and utilization. There was a study that Shelton of the CDC did in Georgia on the relationship between distance and utilization of abortion services. But I think you may be reading something into the concept of regionalization that wasn't there in the first place. I don't believe the idea necessarily implies closing down the clinics in four of the counties and putting it all into the fifth county. I think it implies regionalization of the program administrative staff to gain some economies of scale, and, perhaps, under those conditions you can afford to have two nurses serving five counties rather than having five different half-time nurses in each of the five counties. In this family planning program, we know from many, many other kinds of studies that availability and accessibility (geographic availability, proximity) have been very important determinants of utilization and success in reaching the caseload. So when we talk about regionalization, we are not talking about making it less geographically accessible—we're talking about trying to get, in these very small county programs, to the point where a program staff can be employed that will address problems across county lines.

QUESTION #6: I wanted to add that, too. In view of the data that's coming out now where the administrative cost appears to be averaging about 26 to 29 percent, I wanted to comment that a lot of those who are getting HEW grants are getting hit in the teeth if they exceed 20 percent. What needs to be done about that—about these indicators?

FREDERICK JAFFE: There are some very real problems with those indicators. In all such studies you have to be very, very cautious, because unless you have uniform accounting systems underlying them, you can get all kinds of apples and oranges called administrative costs in different places. I don't know that anybody really knows what the average administrative cost ought to be in a health care delivery system or what it is in hospitals. I know there are a lot of arguments about this, and that the arguments shed more heat than light. Until we do some further analysis of our data, I wouldn't particularly want to get that figure of 26 percent firmly inscribed in marble. The important thing we were trying to look at was, "Is it higher in rural areas than in cities?" Using basically the same method of data collection with the same limitations of data, including some apples and oranges, it doesn't appear to be. Now that's the principal finding.

JOY DRYFOOS: I meant to suggest that we draw something to your attention right at the outset. If you look at the yellow cover, it says in very large print "PRELIMINARY." The other point is that we'll be processing these data—as Regina Loewenstein and I said—we have enough stuff in the data files for centuries of students who will follow us, so we would like to be asked questions like, "Are you going to be able to find out about this, that, or the other thing?" because it will give us some thoughts about where we ought to go next in our analysis.

QUESTION #7: Has there been any attempt at correlating the degree of success in meeting the unmet need in the nonmetropolitan areas with the annual cost per patient?

DONNA FRIEDMAN: We haven't done that yet, but it is one of the first things we want to do. We have basically just come up with the kinds of statistics that we'll have to feed into those correlation analyses, and we're very anxiously waiting to get back to work on it.

QUESTION #8: Susan brought out that there's a wide difference in the percent of women who are served in the rural areas, something like Indiana and a few other states where one in 10 are served and then some other states where it's as high as four in 10 now. Have you looked at the fertility rate in those high and low states and areas and examined what it shows?

FREDERICK JAFFE: We haven't done that yet. I think that's something we have to look at. There have been some studies on the relationship between family planning service delivery and fertility *generally*, but not looking at that question. But we have to begin to ask the question, "Are there differences in fertility outcome that can be attributable to differences in the availability and utilization of these services?"

QUESTION #9: We've consistently challenged the medical community in terms of our cost per patient as related to the total cost of medical care, and I agree with that. We're essentially a low-technology service, medically speaking anyway, and I wondered if there are any figures available at the Guttmacher Institute or anywhere else that compare our kind of service with other similar medical services, and how do our cost per patient figures compare with that?

FREDERICK JAFFE: One of the problems is that there are very few other similar services. This is an ambulatory medical service or health service which by our standards requires periodic re-examination, monitoring, and includes a bunch of diagnostic and screening services which are probably useful, but their relationship to the contraceptive prescription is not totally clear. Most ambulatory care is sick care. Now, *maybe* you could compare the cost of a family planning visit with its concomitant diagnostic procedures with the cost of an annual physical examination. That's the only one that comes quickly to my mind as a comparable.

QUESTION #9: What about well-baby clinics?

FREDERICK JAFFE: Well-baby clinics are an even lower technology service.

QUESTION #9: You could compare the performance rate on the common market, couldn't you?

FREDERICK JAFFE: Yes, you could say, "How much does it cost for a Pap smear here and a Pap smear there?" Well, I don't know what the national cost of an annual physical examination is. In New York City I would tell you it is astronomical. Somebody mentioned I went to China, and I had to get about five or six different shots. The bill for that was astronomical, just to get five shots! Now, I don't know whether that's an appropriate comparison, but I think, off the top of my head, it's very difficult to find an exactly analogous kind of service in the U.S. health care pattern to get an even comparison.

QUESTION #10: You really hit upon a critical point as far as use of these data are concerned, because a service is not a service is not a service, and these comparisons are going to be made. As a matter of fact, an initial reaction might be to just take a different point of view—these are very high costs—given a narrow point of interpretation. It therefore becomes very critical to the successful use of data like these to know what are the services provided in any statistical report, to include the kind of description of the quantity and services. That would get at the quality question as well. So I would hope that when this is put together it does contain that kind of description to give a better idea of what is meant about services to patients.

FREDERICK JAFFE: That is a very important point. If these data are reliable, and that's a question of sampling and response rates, they represent the family planning delivery system as it existed in 1976. Now, from the work we've done under contract to HEW for the Five-Year Plan and the data coming from the national reporting system, we have a pretty fair idea of the range of services delivered in that system in addition to contraceptive prescription: Pap smears, blood tests, etc. I think it's very important when we describe the per patient costs here that we make clear the range of services that are being encompassed. For example, one of the bugaboos is that a visit to a private physician costs less than $66 a year. We don't believe these diagnostic and screening procedures are as uniformly available in the private physician's office.

QUESTION #11: My concern has been that a lot of us very cavalierly banter around this comparison of cost per patient services in family planning and medical services. I'm not sure that's a really fair comparison. I think within our own universe, whether we're talking about a private physician provider or family planning clinic, there may be some comparisons within that about the cost per patient and effectiveness. But if we cannot draw an analogy with other medical services like ours, then cost comparisons in terms of efficacy don't hold much water. But I think we ought to temper our remarks, particularly as we move towards national health insurance, and begin to draw some rational comparisons.

JOY DRYFOOS: In our questionnaire we asked rather extensive questions about type of service, like pelvic, Pap, breast exam, weight, urinalysis, at initial visit at a revisit, not routinely provided, and whether they had genetic counseling, VD testing and the works. So, we have a little problem, of course, coming up with indices of quality of care, but it was certainly uppermost in our minds to get to that fairly early on because, obviously, just simply having a total cost doesn't tell the whole story. It means something, but it doesn't mean everything until we can begin to say what was really purchased as a result of that expenditure.

QUESTION #12: I was going to say that in our area we did do a little bit of word-of-mouth research on how our costs compared with the same costs with a physician. We only found very few ob/gyn doctors who even did as thorough a testing as we do for family planning, and they charged a little over twice what we do.

QUESTION #13: I have a great deal of admiration for what you're undertaking here. I think it's going to be extraordinarily useful. But I'm a non-believer at this point when it comes to rural costs and urban costs. You state in the very beginning something about 1,400 projects, about 2,500 clinics—did you do any breakdown or do you have any awareness of how *they* break down the total level—in terms of number who we are serving, 500 or less, 500-1,000, so forth? And then comparing that total with your sample, because obviously the 500 or less ones are very much, in preliminary data, the expensive ones? Are they proportionately represented in your sample or not? I get the feeling that's not true.

DONNA FRIEDMAN: We hope they are by chance.

REGINA LOEWENSTEIN: The sample was selected by being stratified by the four types of agencies, and a random sample was selected of each type. We didn't have the information about the universe and would not have been able to stratify by many other variables. We hope and assume by probability chance that we do have a representation by the smaller size agencies. As far as I know, the information is not available about the universe—we cannot test it. It's a sound question which I don't think we can answer.

QUESTION #13: Another question about the use of volunteers. Do you have documentation on whether rural volunteer assistance was more or less about the same . . .?

DONNA FRIEDMAN: That also is attached to the site study that we will be doing where we are going to take a really in-depth look at staffing patterns, and that includes paid and non-paid staff, different kinds of staff—medical staff, administrative, other kinds of support staff—so it's really the data we're itching to get into and I know that you're all wanting to hear about, but we just don't have it yet.

QUESTION #14: Is there any breakdown on age, the rural ones we are serving, the sexually active minors, ones we are not serving?

DONNA FRIEDMAN: We went at that question through the back door. We had a section in our questionnaire where we asked people if they had any kind of eligibility requirements that could potentially be a barrier to service for any subsection of the population using this service. We asked whether there were any barriers or eligibility requirements concerning age—were there residency requirements, marital status requirements, income, or any other. By and large, everyone said no, that they didn't have any of those. Now, whether they were reporting that legally or officially they have none, and then what they're doing may be different, it's hard to tell. But, in that we got such a blanket "no" answer, we're really not going into that deeply. However, it is a standard part of our data collection. We do know the breakdown by age within the system.

FREDERICK JAFFE: I'd like to make an observation. First of all, the Institute will sometime in the next few months publish a nationwide teenage county study. It's a study of the proportion of the teenage need in every county in the U.S. that's being met by organized programs—so that you'll get a pretty good picture of whether there are metropolitan and nonmetropolitan differences and where, what states are ahead and what states are behind. I think the study will begin to do for teenage services what the '68, '69, and '71 county studies did for the entire program at that time. The second thing is that I would like to call your attention to Table 22 on page 116 of the factbook which shows something about the differences between metropolitan and nonmetropolitan services to teenagers in 1975. Metropolitan area programs appear to be serving 31 percent of the teenage need and nonmetropolitan areas, 23 percent. Now that looks like metropolitan areas are ahead; but considering the conventional image of recalcitrant, resistant, conservative, rural America where everybody is very concerned about serving teenagers without parental consent and all of that, I would submit that that difference is remarkably small. It tells me there is a lot of activity and progress in the nonmetropolitan programs in reaching teenagers, and by inference I would argue there must be a lot of receptivity in the community. Otherwise, I don't think you could serve the 270,000 teenagers already enrolled in nonmetropolitan programs. They're very loud people; you can't serve them very quietly!

Luncheon: Overview of Rural America

RICHARD J. MARGOLIS

Editor
Rural America

I doubt that I'll solve any of your problems today, and when I'm done you'll still be facing the same difficult challenge, which is bringing the blessings of family planning to millions of rural citizens who urgently need them, and especially to the rural poor. But I might be able to suggest a framework within which you can think about the problem, and that framework I think has less to do with family planning and its idiosyncracies than with the special vicissitudes of rural America and with the peculiar way that we as a nation have come to view the rural sector.

In the first place, the disproportionate shortage of family planning facilities in rural America is part and parcel of other rural shortages. The rural sector is shortchanged all along the front, and in particular, in the long-standing and ever-increasing shortage of professional medical services in rural areas. Rural Americans have been suffering from a persistent health care drain for the greater part of this century. The problem is rooted in the medical market process and the way that medical services in this country are bought and sold.

In the second place, the family planning challenge in rural America has been shaped both by the traditions rural people espouse and by the afflictions they endure. Nowadays, only about one-seventh of all rural Americans live on farms and the rest live in small towns and work in factories or in the mines of our extraction industry, or in some cases—too many cases—don't work at all. Nevertheless, I believe that the agricultural injunction to increase and multiply still plays a role among some rural Americans, and that is—to the extent the role is viable—a barrier to your work. This injunction to increase and multiply rings particularly loud and true among certain rural ethnic groups who have come to see birth control in some cases as the device of the white majority for maintaining power—particularly the native Americans and to some extent the blacks and Chicanos. The radical wings of these groups feel that way. These groups have in the past decade enjoyed a resurgence of racial pride and, for better or for worse, a manifold increase in population.

In addition, there is still a fairly sizable agricultural migrant population. It's not what it used to be, but it's over a million—probably about one and a half million people—and they, because of the nature of the work and the miserly wages that they earn, depend upon children—*their* children—for income. This is particularly true in the southern belt of America, from Florida all the way to southern California. So the migrants have an economic reason to have more children. If they don't, you would have to prove that to them.

And the rural afflictions do not make your job any easier. The illiteracy rate is nearly 50 percent higher in rural America than in urban and suburban America. And we know that illiteracy and family planning, like oil and water, don't mix. Poverty is another barrier. Rural people may comprise only a quarter of the total population, but they represent more than half of all poor people in America. That doesn't make your job easier. Finally, the very shortage of professional health care in rural areas sometimes acts as an impediment to family planning or is an encouragement to family proliferation. I have in mind the infant mortality rate in rural America, which runs considerably higher than it does among the rest of the population. In the case of nonwhite, poor, rural people, the infant mortality rate is double that suffered by the urban white population. So your job is not an easy one and that is probably no news to you. I am sorry to say that your burden will not be made any lighter by a public that frequently views family planning with a tinge of suspicion even now, and rural people with a mixture of scorn and indifference. Let me talk more about that indifference, because I think that comes very close to the heart of the matter—how we as a nation feel about the rural sector—people who live in rural America.

We at the organization I am associated with, which we call "Rural America, *Inc.*," speak a great deal about "metropollyanna," a word coined by our Executive Director, Clay Cochran. Metropollyanna we define as the widespread notion that sooner or later everyone will move to the city and live happily ever after. The myth of "metropollyanna" has saturated America's unconscious and distorted its policies in ways that have been self-fulfilling and disastrous.

If you want to get an idea of how our unconscious views rural America look at the commercials on television and you will see—not only the commercials but you can watch "The Little House on the Prairie" and "The Waltons." You will see rural America portrayed as a dead letter, a piece of "camp" nostalgia having nothing to do with the present. We now have a product put out by General Foods called "Country Time." It's supposed to be lemonade, just like the lemonade Grandma *used* to make. We can actually drink the past by drinking "Country Time." It happens to be all chemicals but never mind. And the commercial, you may have seen it, that promotes "Country Time"—I call them front porch commercials—there is a front porch and some very amazingly elderly people on this porch. They're playing checkers. Heaven forbid they should be playing something but checkers! And one of them is deaf, so he has to repeat things all the time. That's how the pitch comes because they repeat it to him. That's a corollary of "metropollyanna." Sooner or later everyone is going to move to the city except one or two old men who play checkers.

This affects our policy. Over the decades Congress and the executive branch have tended to just write off all those citizens who happen to live in small towns in rural areas and to siphon the bulk of federal funds and assistance into the cities and suburbs. I don't fault whatever support we can give to the victims of urban life, but there is a tendency to forget, as we talk about the crisis in the cities, the other crisis that has been with us much longer and which in fact has to some extent been the cause of the urban crisis.

So to this day few Americans fully understand the ruinous consequences of this siphoning process. For example, when Rural America was called the Rural Housing Alliance in one of its previous incarnations about 10 years ago, we discovered that two-thirds of all the bad housing by census definition existed in rural America, and HUD was earmarking five percent of all its subsidies for rural housing. There was obviously a discrepancy. So we took the census figures to HUD officials and they assured us that we had made a mathematical error. They said that everybody knew that the housing problem in America was urban and not rural and that's why they had a

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"U" in "HUD." Clear? Well, we checked our arithmetic again and it still added up, so we went back to HUD and told them that no matter how you sliced it, 66 percent of all the indecent housing was still out there in rural provinces. This time the officials said something else. They said, if *your* figures are right then the *census* must be wrong! And they were as good as their word; they offered to take those figures and put them back in the computer and shake it up again and see what came out. And they did. It took them three months, but there was no hurry because the bad housing had been out there for centuries. And when the numbers were all winnowed and sifted and transcribed into neat tables, what do you think they found? Two-thirds of all the bad housing was still out there. Unshakable reality. But to this day HUD does very little on rural housing.

The upshot of all this—of metropollyanna—is what we call "placism." Placism is simply discrimination against persons by virtue of their place of residence, and we have discovered that this is a placist society and that the chief victims are those who live either in the urban ghettos or the rural slums. And the banks redline their shacks and their tenements, and the highway engineers either displace the slum dweller or bypass the villager, and the states resent urban welfare and shun rural development, forgetting that the two are related. Across the board there is placism that we all practice and don't think much about unless we happen to be associated with something that pertains to rural affairs.

In your own field examples of placism abound. According to data from the National Ambulatory Medical Care Survey, in 1974, eight percent of all nonmetropolitan women in need of family planning care received such assistance from private physicians—only eight percent—and in metropolitan areas the comparable figure was 25 percent. Something was wrong. Similarly, federal family planning programs have lagged in rural areas, as you have heard earlier today. By 1974, these programs served 91 percent of the metropolitan counties and only 72 percent of the nonmetropolitan counties. Now, these figures come from something you have probably already read —a study by Toni Heisler Firpo and Deborah A. Lewis: "Family Planning Needs and Services in Nonmetropolitan Areas," which appeared in *Family Planning Perspectives* last year. They note in summation that more than two and a half million low-and marginal-income women living in rural areas are still without access to family planning services that they want and that they need. So one of your jobs—at least tangentially as you go about your main job—is to stamp out metropollyanna and placism.

I promised to talk a little about the health care system per se and how it relates to rural areas—the way health is distributed and the way it isn't distributed. Everyone knows that rural America suffers from a doctor shortage. Only 12 percent of all our physicians and 18 percent of our nurses practice in rural areas and small towns. At last count there were 138 counties, including more than 5,000 separate communities, that had to struggle along without the services of a single physician—138 counties without a local doctor. I have heard many reasons cited for this and they are probably all true. But it seems to me the underlying reason is the marketplace, and that doctors—like the rest of us—follow the market or the dollar, and that over the years the dollar has become a rather scarce item in the rural sector.

One of the functions of the free marketplace is to distribute services with some equity. But in the health care system we have no free marketplace for a number of reasons, one of which is that it has been professionalized. The physician's profession is probably the best example of this. Once you professionalize you set up a gatekeeping set of standards, so you can let a few in and keep many out. The free market suddenly goes kaput. What you have instead in health care is an oligopoly. Ever since the Flexner Report was published in 1910, which exposed the shoddiness of many medical schools and caused them to either merge or fold, medicine has been more of a seller's market. The new system allowed doctors who had not been doing very well up to that time—financially or in status—to seek a more monied clientele and in many cases to leave rural America and go into the cities and suburbs where a better market existed. I am saying that the economics of all this has been taking its toll for the better part of the twentieth century.

As far back as 1925 this was noted by the AMA. They said something then in the AMA Journal which sounds as if it could have been said today: "There is a universal tendency for physicians to abandon rural districts in favor of the cities." That was in 1925—half a century ago—and they said: "In hundreds of rural districts medical care is inadequate or absolutely lacking." Yes indeed. Things in general got worse rather than better since the AMA cited that problem in 1925. We have permitted the medical profession to make all the key decisions. We have permitted them to decide where they practice, what they practice, what we buy from them, and how much we must pay in exchange for what we buy. I don't think we can afford to keep doing this. I think as soon as we finally commit ourselves—and I mean really commit ourselves—achieving health care equity in rural America, at that point we'll see that the old fee-for-service system just doesn't work anymore, and that although it has brought much wealth to the medical profession and quite a bit of health care to many of us—good health care—it is no longer practical. Something else is going to have to be substituted for that old system. Something that is now nameless and largely unformed. I think that when we finally get around to putting a name on it and shaping it, it will at least include a large corps of salaried physicians, probably paid for either directly or indirectly by us, the federal government and us taxpayers, and that corps will be dispatched to all corners of the land and not simply where the dollars are.

Now in closing I would like to ask your indulgence to allow me to do two things. One, I want to tell you a story that sold me on family planning in rural areas, and, secondly, I want to read you a poem. The story happened to me several years ago in Rosebud Reservation, South Dakota among the Sioux Indians where I had been a consultant on another matter. It was at the height of the militant American Indian movement and many of the leaders at Rosebud and adjoining reservations were equating family planning with genocide. Well, one night I found myself alone in a rented car driving down a road from the village of Rosebud to the village of St. Francis. I was going to make a speech in St. Francis. And it was dark and there was a car ahead of me on the very narrow road. The car lurched all over the road. I couldn't pass it—and it was going very slowly but very erratically—and it was, as many cars on reservations are, stuffed full of people. And as I tried to pass and then gave up and resigned myself to being late in St. Francis, I noticed some dark object being thrown out of the window, and I put on my brakes because I was about to run over this package. My headlights caught it and I couldn't tell what it was and I stopped in the middle of the highway and I noticed that they stopped, too, farther on. Their car came to a screeching halt. I picked up the package, and it was a baby in a blanket. There I was, holding this baby under the Rosebud moon and wondering what to do next. A woman came running back from the other car and told me that this was her baby, and somebody—she thought her husband—had thrown it out the window. They were all very drunk and didn't know what to do with the baby. Well, we got the baby to a missionary which was the last I saw of any of them. But it occurred to me at the time that if you have such misery on a reservation and in many other places in rural America that life literally gets thrown out the window, then you need family planning. And that evening I was converted. I became a believer with you.

Now I'll read you a poem which is on the same theme. I suppose the theme is my conversion. I wrote it a number of years ago after I interviewed a black mother in Georgia who lived in a shack and had many children; I think it dramatizes the need for, and the impulse toward, family planning in rural America. I had asked the mother what it was like to live amidst such a crowd, and she said: "I keep yelling at the children. I keep saying 'out of my way—can't get by.' " She said, "I try to stop, but I can't." So when I got home I wrote this poem:

Out of my way, can't get by.
No place to play, can't get by.
You're on my feet, can't get by.
Stand up and eat, can't get by.
Tryin' to clean, can't get by.
Hate to be mean, can't get by.
Get away from that stove, can't get by.
Told you to move, can't get by.
Can't get by, can't get by, can't. . .
Lord, when I die, just let me by.

Panel Discussion

Rural Family Planning Programs: The Provider Perspective

Moderator: Jack Leath
Director
Division of Family Planning Services
Tennessee Department of Public Health

Participants: Betty Canterbury
Manager
Family Planning Program
Southern West Virginia Regional Health Council

Sheri Tepper
Executive Director
Rocky Mountain Planned Parenthood

Zina Worley
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Family Planning, Region 9
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Gerald E. Sussman, Ph.D.
Assistant Professor of Public Health Administration
The University of Texas Health Science Center
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Catherine P. McDowell
Director
Family Planning and Education Center, New Hampshire

Reactors: James L. Reitz
Area Manager
Family Planning Council of Western Pennsylvania

Allan Rosenfield, M.D.
Director
Center for Population and Family Health
Columbia University

Areawide Program/ Nonprofit Corporation

BETTY CANTERBURY

Manager, Family Planning Program
Southern West Virginia
Regional Health Council

Program Description

A new concept in comprehensive health care planning and delivery became a reality in the nine southern most counties of West Virginia with the establishment of the Southern West Virginia Regional Health Council, Incorporated, in February, 1968. Forging an alliance between the public and private sectors of the community and the health professions, the Council developed a comprehensive regional response to health care delivery.

In February, 1968, the nine-county area was designated one of eight "demonstration health project areas" in the 13-state Appalachian Region and awarded a grant for planning and development by the Appalachian Regional Commission.

The Southern West Virginia Regional Health Council in its initial funding request (January 1, 1972-June 30, 1972) for family planning services from the Department of Health, Education and Welfare's National Center for Family Planning Services coordinated its efforts around two basic goals. These two goals were:

- Making high quality medical family planning services accessible to the estimated 27,000 women of childbearing age thought to be at risk of unwanted pregnancy in Southern West Virginia.
- Through family planning services, introducing medically indigent families into Southern West Virginia Regional Health's comprehensive program of health and medical care.

The Southern West Virginia Regional Health Council believes that universal access to high quality, comprehensive medical care is a birthright rather than a privilege. To implement this belief, the Regional Health Council is attempting to provide a full range of preventive and curative medical care to the people of Southern West Virginia, including the integration of family planning services into the total health program.

Number of Patients

The Council, serious in its commitment to the delivery of family planning services, has an enrollment worthy of note. The following break out of enrollment, by calender year, documents this.

YEAR	NEW PATIENTS	REVISITS
1970-1971	1,679	2,275
1972	2,302	3,432
1973	1,931	4,110
1974	2,200	6,433
1975	3,033	10,271
1976	2,229	7,934
TOTAL	13,424	34,555

Modalities of Delivery

The Southern West Virginia Regional Health Council, in an effort to meet the needs of the population of the area served, uses a variety of modes of service delivery. These modes are: (1) integration of family planning services in a comprehensive health care system; (2) mobile unit/mobile team; and (3) mobile team/fixed unit. The decision to use a particular modality of delivery is based upon several factors. These include: density of population; availability of health manpower and availability of adequate facilities.

Staffing Patterns

The uniform clinical staffing pattern is coupled with non-clinical support staff. A clinic team consists of team leader—registered nurse, post-examination nurse—L.P.N., nurse's aide, laboratory technician, clerk, social worker/counselor, physician and/or physician extender. The non-clinic staff are the outreach workers. Their duties are to recruit new patients, provide health education (either to groups or to individuals), and to follow-up missed appointments.

Care has been taken to build flexibility into the clinic structure. To expedite the clinic flow, each team member has a general understanding of required functions, other than her own, and thus is able to assist other team members if "jams" develop.

Financing

The program is financed through the Department of Health, Education and Welfare, Title X funds and through Title XIX and XX funds. All of these funds are received in a fee-for-services agreement with the West Virginia State Health Department and the Statewide Family Planning Project. The agency also has developed the mechanisms for collecting payment from private sources when this situation is applicable. The United Mine Workers of America also reimburses for the family planning services provided to the beneficiaries of their medical funds.

Development of Program

The development of our particular type of family planning program was, in many ways, predetermined by the existing structure of the Appalachian Regional Commission funded program activities and facilities. Other determinants leading to the development of the program were the existence, or lack of same, of health care facilities. In a rural area such as ours, the few existing facilities are generally located in the county seat. Our efforts were to maximize on the existing systems.

Historically, choices in delivering health care are limited by the amount of funds available. Family planning is no exception to this. The number of sites and sessions were dictated by the amount of the grant.

Particular Problems

The problems which can be classified under "Acts of God" include flooding, blizzards, and terrain. The problems created by "man" are even more difficult. The political subdivisions, which have some authority over the lives of certain segments of the population, have differing policies, procedures, and philosophies. For example, a local Board of Education denies the program the entree to the classroom and therefore to the student population in need of health education. By the same token the local Welfare Department is "put-out" with the program because it is not educating the student population on family planning, birth control, etc. This is an example of "power house" dictating in opposite directions. This is indeed problematic to a family planning program.

Interestingly enough we have had no problems with organized church groups. In the Spring of 1973, we conducted a survey of ministers in our area. The objective of the study was basically two-fold: (1) it attempted to determine general attitudes about sex and contraception as held by the ministers in the eight counties covered by the questionnaire; and (2) it also attempted to determine whether ministers could be valuable sources of referral of support for improving the quality of family planning services and knowledge in this region.

The Yellow Pages of the local telephone directories were used as the source of names of ministers in the area. I realized that not everyone who was listed as a clergyman in the phone book would be an ordained minister or a graduate of an accredited seminary, but the main concern in this study was to find persons in the community whom the general population went to for advice and counseling, regardless of the ministers' credentials. Generally, a strong majority of ministers were in favor of family planning as a valuable health practice. Ninety-nine percent felt sexual harmony is an important factor in marital stability. Eighty-six percent felt there is a need for increased awareness and acceptance of family planning services in their counties.

A particular problem with our program has been the economy of the region. It is a rural, non-farming section in which an extractive industry (coal-mining) is the principal industry, and this is an industry which has a history of high and low employment and also of labor problems. These factors determine, to a very high degree, the population to be served. If the employment is down the out-migration is heavy; if employment is up the in-migration is heavy. At this point in time we are experiencing an in-migration. The population is generally of childbearing age and demanding on the available health services. In the early days of the program the area was among the highest in unemployment in the county. This means that a program serving an area in which the population fluctuates must have enough foresight to plan for these changes.

Also, another problem associated with in-migration to an area like Southern West Virginia, is the fact that the returning population are rarely transferring skills in health manpower. Rather, the returning population are making greater demands on an already inadequate health system. I would consider the above problem one of major concern for all rural programs, as the country is experiencing a marked shift in population trends toward rural living.

Manpower

In areas in which a clinic site was needed to be developed but in which there was a shortage of manpower, the mobile team/fixed site modality of delivering services was implemented. In situations in which the site could be staffed by the local health professionals through contracting with them for part-time employment this was done. I like this use of local manpower in that the identifications are much stronger.

There has been a lack of cooperation on the part of some physicians due to the demands already on their time. This is understandable. It is through these kinds of development that we have been able to establish a case for the use of the nurse practitioners.

Also, in an effort to overcome the critical health manpower shortages in this state, the state colleges have developed excellent allied health programs, as well as increasing the enrollment in the schools for the health professionals. We were not directly involved in this, but can make recommendations to programs which might be in a position to be supportive of this sort of planning.

Change In Approach

With the given political climate in public health during the time of the implementation of the program there could be very little change or differences in the approach to the delivery of family planning. If that political climate had been more favorable, major changes, which would have been positive for the delivery of family planning services, are: (1) increased media coverage for a higher program profile; (2) expanded inter-agency activities and referrals; (3) expanded speakers' bureau, including volunteers; (4) a more active consumer's advisory group; (5) regularly scheduled activities through the local Boards of Education; (6) in-service training for the staff on a regular and progressive basis; (7) testing modalities of delivery for greater efficiency; and (8) expanded patient education to include an awareness of their rights to health care. The proverbial "hind-sight is better than foresight" is not applicable, as family planning is yet a new and exciting program.

Unique Problems

The concept of rural is presently undergoing such major changes that it is difficult to frame rural in any one well-defined perspective as might have been the case several decades ago. In these southern 10 counties of West Virginia "rural" is yet flavored with isolation. However, with the recent energy demands placed on the coal mining industry there are healthy patterns of change. These indicate isolation is being replaced with the pressures of the late twentieth century, including traffic, shopping centers, housing development, etc. Rural living is so often associated with sub-standard living conditions, including inadequate transportation systems. As such, the problems of delivering family planning services are compounded. By the same token the need for them is intensified. It seems as if each program must clearly define "rural" as it relates to their program. Then they can develop modalities of delivering family planning services which best meet the need of their area.

The unique problem to our rural population, in the majority of cases, is that they had no other choice. Rural living was an inheritance, with the accompanying lack of access to health care, recreation, employment and education facilities. For many Americans rural living is a choice with a "benefits package" they sought. To all of these family planning has a responsibility—it is to the "no-other choice" group that the task can become laborious and expensive.

Statewide Planned Parenthood Affiliate

SHERI TEPPER

Executive Director
Rocky Mountain Planned Parenthood
Colorado

After 15 years as the director of a Planned Parenthood affiliate which has for the better part of those 15 years had a strong rural component, I've just about come to the conclusion that the crisis point in providing service in any area, including a rural area, is to decide who the service is for. Who are the consumers? Whose interests are being furthered? Whose ox, assuming someone out there has an ox, will we allow to be gored? Is the service run for the benefit of the local physicians? We have at least one that was started for the benefit of local physicians. Local public health department? We have at least one that was started for that purpose. Local political body? Local staff? Or are we really providing the service for those who want to use it? And do those who are using the service today really represent all of those who would use the service, if it were just somehow different? Or somewhere else? Or didn't have Dr. Grinch as a clinician? Or didn't have that great big plate glass window right across the window from the Catholic church?

Now those questions are not really different in kind from the questions we ask about urban services. But they are a little different in quality, because the quality of the solutions is a little bit different. In an urban area one might say, "I'm dreadfully sorry, Dr. Grinch, but we don't really feel you are suited for clinical service." And he might say in return, as one physician did, "God, I'm glad you noticed it. I thought it was just me. I had thought of going into research." We said, "Good, good."

Yes, in an urban area you might fire Dr. Grinch and you might hire Dr. Mellow, but in a rural area Dr. Grinch may be the only ob/gyn in a hundred miles, and there is no Dr. Mellow. And in a rural area that storefront with a big plate glass window right across the street from the Catholic church may be the only facilities game in town. And feelings get hurt in rural areas because everything is so exposed. If one rubs someone at the health department the wrong way, you may be sure that virtually everyone in town will have taken sides by tomorrow morning. And the local board of health may be expected to have strong feelings about everything, and because there are fewer everythings, they can concentrate a lot of attention on every one of them. And they have a lot of room for expression. And despite all that, you have to really ask the question, "Who's the service for?"

Now, our articles of incorporation are nice and unequivocal on that point. Our articles of incorporation say that our purpose is to provide birth control services to anybody who wants them. And they don't say in any given county, and they don't say in any particular group, and they don't say with the following restrictions, and they don't say considering X, Y, and Z. They say provide birth control services to everyone who wants them.

That being the case, the decision is made for you. Because if the service is for all the people in that area, somehow you've got to find a way to fire Dr. Grinch, move out of the store across the street from the Catholic church, get around the local board of health, and somehow fix the situation so the person at the local board of the health department whose feelings have been hurt does not interfere with the delivery of family planning services to people in the area. And one can do none of those things if one is a captive of the local political system, unless, as must occasionally be true, the local political system is based on providing consumers with what they want and need. I haven't seen one, but I'm not saying it can't be true.

Because it's not often true, however, there is a structural struggle which has to precede the solution of local problems. And I have been engaged in that structural struggle the last 15 years of my life, and I'm looking forward to retirement. In one county it came in '68, another in '69, another in '70, and another in '71, and in one frantic year we moved seven clinic sites in order to gain some autonomy or neutrality from the politicalization going on. In each case what we tried to do was separate ourselves from the factionalism that seemed to permeate the delivery of all kinds of services, a brief description of one or two local services—and honest, I have somewhat obscured the details here so that we don't get up for slander—I'm very careful these days; our legal fees have doubled in the last two years.

In Hoople county, for example, we have an office in the county courthouse right across the hall from the social services department, and the secretary in the social services department is a native of the community and knows almost everybody, and she has very strong views about service to teens without their parent's knowledge. So whenever a teen comes into the service, if she recognizes the teen and knows the parents, which it being a small town she usually does, she would get on the phone, call the parents and say, "Do you know that your daughter is down here in the Planned Parenthood clinic?"

Now, the secretary to the local social services department had been hired out of political reasons and had rather strong support on the local welfare board. Quite frankly, it was unlikely that had we raised the issue any disciplinary action would have been taken. As a matter of fact, we might have found ourselves out on our ear. So, seeing that as an absolute probable thing that was going to happen to us anyhow, we moved. And the clinic load doubled in the following six months. Now the rent was a lot higher, but the per capita rent, per patient, was lower than it had been before.

In Whiffletree county we shared quarters with the local public health department. Now the rule of the public health department was that only doctors who belonged to the county medical society could work for the public health department. The county medical society kept very careful tabs on who was to be a member of it, carefully excluding any person with socialistic tendencies, who might have once, for example, worked for the unions or given free care, or worked for one of those feminists bunches. Now, Dr. Grinch was a leading member of the local medical society. Dr. Grinch really didn't like people much. He liked women less than most people.

There was another ob/gyn in town, a female one, and she'd worked for the unions, and so we couldn't have her as long as we were in the public health department. So we moved out. The clinic load took nine months to triple. We had been in that community for five years. We just didn't know how much they didn't like Dr. Grinch. Now it cost us, too. And it costs us more to hire Dr. Mellow, but the per capita medical costs decreased.

Then there was the community in which we happily shared space with the local public health department for a number of years, and in which the residents in ob/gyn from the medical school came 200 miles once or twice a month for a combined maternity/family planning clinic. Of course, there were 10 family planning patients for every maternity patient, but it was billed as a resident education program in maternity services by the medical school. The local public health department moved into the new, elegant hospital, which was built some five miles out of town on, we understand, land that had previously been owned by a member of the county commissioners. Of course, our patients couldn't get there very easily. Some of them couldn't get there at all, and so we moved out. Now the residents of the medical school weren't allowed to work for us, because we are not a city or county agency, and because the program was billed as a maternity program. So they continued to come 200 miles a month to see the four maternity patients that showed up out at the hospital. We contracted with a friendly doctor in Sante Fe to fly in. It's more expensive for us because the other way the costs were shared, but the load continues to grow, and at least the patients can find us where we are.

Now we could multiply these incidents over and over, but we've learned some lessons from some of them. And that is in any community where politics are at work and highly visible, and most politics are highly visible in a small town, if one wishes to design a program to serve anyone, everyone, the political issues and personalities, insofar as possible, must be avoided. The secretary in the courthouse, the choice of the location of a new hospital, the politics of the county medical society—none of those had anything to do with family planning. Family planning was never considered in any of them. And yet each of them limited the success of our local program. This is more often true in a rural area than an urban one, because in those rural areas the influences are fewer and less likely to be diffused and diluted.

Another implication of the cases I've just described is that when we moved, we were able to offer in each case a slightly more private anonymous service. Now we don't believe that people in rural areas are more nosy than people in urban areas. We are all nosy about people we know. It's just that in rural areas you know a lot more people. And we do find that if you have a service and it's doing family planning and it's identified as doing family planning, it helps if it is not right across the street from the school, right across the street from the employment office, right across the street from anybody where people are going to watch who goes in and out. Now I will not fib to you and tell you every patient greeted these moves with cries of joy. Some of the patients prefer a one-stop, multi-service kind of thing. They like to be where they can go into the welfare office, the public health office, the family planning office, the school counselor, the employment office, all in one location, as the county courthouse was. They tend to be older women, usually with larger families. Each time we made a move we lost a few patients, but those that we lost were vastly outnumbered by the number of new patients coming in.

One of the advantages of neutrality, or nonalliance, with local political or personality issues is that the program can be judged, evaluated, or audited on its own merits. And when the county commissioners get together to distribute local revenue sharing funds, they sometimes can provide funds to the local family planning clinic without regard for its political ties. If it's moved out, if it's autonomous, it has none. We have been the recipients of quite generous amounts of these kinds of funds in various counties over the last three years. We're not supported by local taxes, so we don't come in for the particular kind of criticisms that are leveled at local tax supported agencies. We don't have to do anything in the local area, so what we do do can be measured by the people utilizing the services. We remain free from local opinions as to whether or not we should serve teens—our policy is statewide, and we will. We remain free from whether or not we should charge fees—our policy is statewide, and we will. Whether we should hire Doctor X or Doctor Y—our policy statewide is that we will hire the doctor that relates well to the patients.

The judgment we use is the judgment of the marketplace. Is the service utilized?

Here I'd like to throw in a parenthetical remark about the study that was quoted this morning in which I was amazed to see the tiny percentage of persons with incomes over $10,000 utilizing the various family planning services. We don't have a lot, but we have considerably more than show on most of the percentages in those tables this morning. This is what I would call the judgment of the marketplace. People with incomes over $10,000 can pay something for our services. If it is not of sufficient quality that they want to buy it, why should we consider it of sufficient quality to give to the poor?

Our similarities of attitudes throughout the state can take effect because we are a fairly large agency. Our fiscal year ended last week and we saw 40,000 individual patients. Our rural programs are managed as a part of a total program in a way that builds their local neutrality and protects them as far as possible from local pressures. You all are aware of those local pressures. If you don't protect the local program, particularly a small one, from local pressures, it can politically be blown every way the wind blows. You will do this, you won't do that, the school will do this, the school won't do that. The kind of thing that was mentioned here a few moments ago—you can get in, you can't get in. If you can protect it insofar as possible from those local pressures you can give it a kind of longevity and stability that's going to help it get in there and get the job done. We begin to learn, if we can give them that stability and longevity, more about patient needs, not what we think they might be, but what they really are. When we have a limited choice, and you can offer the patients only the choice between Dr. Grinch and Dr. Glop, or site A or site B, you're not really finding out anything about what the patients want. But once you're able to really think flexibly about rural programs, we begin to find things out that we perceived only dimly in the past.

For example, we had always been told that you have to take the program to the people. We talk a lot about service delivery, like it was a pizza, hot to your door. Well, coats don't deliver, shoes don't deliver, groceries don't deliver, tires for the car don't deliver, and yet the people, even the poor people who are coming for our services got all of these things. We said to ourselves, "Where do they get their coats? Where do they get their shoes? Is it necessary to have the service next door? Where should the service be? Where is it most convenient to have it? What are the marketing patterns?" And we found out that rural people market just like anybody else. They are a little more irregular because much of their access to the marketing center may be based on the weather. When the weather is really lousy in an agricultural area, that may be when you go to town, because you can't do anything else. We found that if we had clinical services that were flexible in time so that people coming into the market center could visit them while there, we didn't need to worry about so many different sites. One site would be quite enough for quite a large area.

Another problem was that you don't have a doctor there all the time. We couldn't afford a doctor there all the time, but when the era of the nurse practitioner came in, then we could say, "Ah, now we've got it." We have found that we can increase patient loads in our rural area clinics 10 to 20 percent merely by having the nurse practitioner in there to take drop-ins.

The doctor, of course, will still be there to take care of problems, to take care of people with things that need different kinds of follow-up, but the nurse practitioner can take care of over 80 percent of the visits on a drop-in basis, and they love it. Mrs. Jones comes in with her sister from across the county, and somebody gives Miss Smith a ride, and they both come in and so forth. A load of teenagers will come over from a small community. To the back door. We're getting reliant on the nurse practitioners, perhaps too reliant, which means, of course, that we are going to face a whole new array of problems. It won't be long before the state decides to license them, and the university will set up academic requirements, and the county medical societies will decide whether they will or will not accept them. The requirements will raise the cost and the length of training and the cost of trained personnel, and then we will find that we can no longer get nurse practitioners to handle the drop-in patients in rural areas. It's difficult now, and as the training gets more expensive and lengthy, it may be impossible. And that brings us to the question that has twice been mentioned here this afternoon—the question of manpower in rural areas.

It would seem to me that in rural areas with a much smaller volume of service, perhaps decisions do not have to be made among 30 patients who are waiting in a split second basis. Personnel might not have to be trained to quite the extent that they might have to be trained in a high intensity urban service. I'm not suggesting that they go untrained and somehow muddle through, but I am suggesting that a rural staff might be trained to some middle level of expertise, and that those of over a rather wide area might share a staff of phone-in consultants or something of the kind. The great benefits of the barefoot doctors in China will be lost whenever every barefoot doctor has to have a medical degree. The great benefit of the nurse practitioner may be lost if every one of them has to graduate from a nurse midwifery school or some equivalent training. I don't think we are going to solve the rural manpower question by demanding more and more training for fewer and fewer people. What we need is more people with mid-level training to do the work in between the professional medical person and the patient.

Our constant problem with rural services is staffing. We can, over a period of a few years, hire local nurses or non-medical staff who are from the local area and train them to function effectively as screeners or program managers at reasonable cost, which represents a career advancement for them and a suitable expenditure for us. Such staff members are likely to stay a long, long while. But nurse practitioners who have had years of training in hospitals or medical school settings are often not satisfied either with the salary or the pace of a local rural service. They want something bigger, brighter, and faster. That is, after all, what they were trained for.

Most of the health corps physicians in rural areas feel pretty much the same way. They'd like something better paid but something with the hours not quite so long. All rural physicians seem to be overloaded, and to ask them to staff additional clinics for a family planning service is often expecting far too much.

I was glad to hear our luncheon speaker mention the staff physician, the salaried physician, because that has been our solution. We have now two, and we are attempting to hire more restricted-hours staff physicians, doctors who have decided they do not want to work themselves to death but who will work for us on a four-day-a-week basis and will go anywhere that we need them—by plane or car or however we need to get them there. In that particular situation, the flexibility of a large program is of inestimable value. If Dr. A goes back to Chicago, at least you can fly Dr. B in from Denver. And if a nurse practitioner has departed for the West Coast, which seems to be a favorite place for nurse practitioners to depart to, you can at least bring in the nurse practitioner from a nearby county, but those are only fill-ins, small expediencies. The real solution has to be to train a lot of these mid-level people who can work between the professional and the patient needing the service.

I have some local problems which may interest you. Isolation has been mentioned. Here in the East and Southeast, I don't think rural means quite the same thing it does in the West and Southwest. The two ends of our program are 700 miles apart. We have 39 service sites, and 700 miles between the two ends of the program. You can drive a hundred mile segment of that 700 miles and never see an animal or a human being. Or vice-versa. And that's isolated. Rural means a town of a few thousand people or a few hundred people 40 miles from any place else and a hundred miles from any place of any size and a long, long way from a city. That means isolation. That means it's difficult to get people together. It's not impossible, it's just difficult. It costs about $1,100 just in mileage for our managers to get together, and that means with the one farthest out picking up the next one as she comes in, and they're all sharing a room when they get it. It's all cozy. We have managers' meetings about once every two months; we need them more often. Area administrators and our consultants fly or drive among those sights all the time, and both our travel and phone costs are enormous, but our per capita cost is still low. And it's low because with that many programs going you've got a tremendous enthusiasm that builds, and you've got a cross-fertilization of ideas and solutions.

How do you know what a clinic in a town of 5,000 ought to be doing unless you can compare clinics in towns of 5,000, several of them, and see what they are doing differently? When you've got several of them that you can really compare, and you can say what are the doctors' costs in this one as compared to the doctors' costs in that one, and what is staff cost here versus staff cost there, in rent and supplies? How come they are getting such good results in schools in this one, and the other one isn't? That's when you've really got a grip on your overall programs.

Costs are higher, we think, in rural areas. Now, our computer says they are, but they are not enormously higher. We feel that they don't have to be terribly high, and when we see costs of over $100 per patient in a program that's been there for a year or two, we wonder who's doing what to whom with what in that program.

One of our other minor problems is the problem of working women. We have a large Chicano population in the southern part of the state. We hire a lot of people who have no cultural tradition of women working outside the home. We hire people and train them to be managers, and they do community work, management, fundraising, make appearances on local radio, give stories to the local papers, hire and fire employees, become very visible. And that visibility is sometimes hard for families to take. We have half-a-dozen staff members struggling with some aspect of marital problems because of their visibility in their work in the community.

And, of course, another one of our problems is the problem of creeping service. If you have an ob/gyn flown in from Denver, and he's the only doctor this woman has seen for six months and the only one she's likely to see anytime soon, it's awfully hard not to look at her skin rash and write her a little prescription for that, even though it doesn't have anything to do with family planning. Or talk to her a little bit about her gastritis or some other problem that she may have.

The greatest problem in providing rural service is the fragmentation, politicalization, do one thing this year and another thing next year, that comes by making all of our medical services part of our political system. There's no policy on medical care in this country. There's no consistency. There are half-a-hundred warring factions. And the people in rural areas suffer from it just as we all do.

In 1975 we could not recruit family planning patients in one rural area because millions of HEW rural health dollars were being poured into that area to support Health Maintenance Organizations. Two years later we don't have the money to pay for family planning in that area because all the Health Maintenance Organization's "rural health" dollars have been withdrawn. There seems to be a great fondness for pilot projects based on the premise that if people are shown how to do a thing expensively and inefficiently they will continue to do it after the money is withdrawn. And again the judgment of the marketplace is seldom applied. We do not find any difficulty in recruiting patients in any areas. If there is any difficulty, we look first at our staff. There may be something wrong. Or our location. There may be something wrong. Rural people buy their coats and their tires and their shoes and their groceries just as we all do. They get to their market center. We look at our scheduling. If they can't get to our center when they get there for other things, there may be something inflexible and unyielding in our schedule that needs to be loosened up.

Our results are now that we are serving about 16,000 women a year with contraceptive services in rural areas. Those are western rural areas. I have not included in that any of the four counties surrounding Denver area or Colorado Springs or Pueblo. But I have left in the other service sites. Of our 39 sites I would say that 27 are rural. I have left in the services in the farm and ranch-based counties, even though there may be a fairly good sized town somewhere in the middle of that. It is not a record with which we are particularly satisfied, but rural patients make up 52 percent of our patient load in our subsidized clinics. And we keep working at the problems, intending to make rural services better. For those of you who are interested in such things, our urban patient cost during 1976 was $35 per patient, and our rural cost was $56 per patient. For an average per patient cost during the year of about $46 for subsidized services, our quality was good; our quality was acceptable. This year, because of the increase in volume, our latest study has indicated that our average cost across the state will be down about two dollars to about $44. Now I'm not interested in cutting costs just to be cutting costs, but it seems to me that every time you could pair two dollars off a per capita cost, and you put enough of those two dollars together, you've got somebody else you can serve. That's what our articles of incorporation say we're all about.

Regional Health Department

ZINA WORLEY

Program Manager, Family Planning, Region 9
Texas State Department of Health

Texans are traditionally interested in tall tales, and a popular story which has made the rounds there in the past few months concerns the three biggest lies told in America today: "I put a check in the mail this morning; I will respect you just as much tomorrow as I do tonight; and, I'm from the government—I've come to help you." Something important can be learned about rural America from the popularity of that story.

Until Dr. Sussman, with a wider knowledge of family planning in various parts of the world, paid Region 9 several visits, we had little awareness of how our program differed from others. We had been so busy making things work and making do and getting services to those who needed it, that we only knew what we were doing. Our program started as a volunteer effort, and even those persons who firmly predicted our failure were on our side and sincerely wished us well. We had all the classic reasons for failure—machismo, cultural taboos, an agricultural (migrant) economy, a largely poor, non-English speaking Roman Catholic population. What's more, we had no money.

In our southwestern sheep ranching area, right across the Río Grande River from Mexico, women traditionally began childbearing early, and families of 12, 14, 16 were not unusual. The only family planning most of the poor knew about were the illegal abortions across the river and "the operation"—the post-partum tubal ligation done by some compassionate doctor delivering a tenth or twelfth baby to a woman whose health hung in the balance.

A small story in the local newspaper invited those interested in starting a family planning program to meet in the basement of the Methodist Church. It brought together a handful of people ready to work at it. Several sympathetic doctors agreed to see patients in their own offices between paying patients, and the city offered office space for volunteers in a building housing the local health department.

There is not enough time here today to trace the history of that beginning volunteer effort to the present Texas Department of Health Regional Program, but there are some basic elements which have remained the same since we first opened our doors. These elements appear to be essential in the successful delivery of any rural family planning program. It must be accessible, and it must be caring. There are other needs—money, supplies, expertise—but unless the caring exists, the best-equipped, most sophisticated, and even the most accessible program would have but limited success in an area such as ours.

We care about the woman who comes in. Not just *women*—in the plural—who want family planning, but *this* woman, and her problems. Her problems may include a brutal husband, a sick child, puzzling application blanks to be filled, or any of a hundred other things. We listen, and we help her—or we find help. We have delivered food, Christmas toys, shoes for school children, found beds and heaters, and traced birth certificates needed for Social Security benefits. We have gone with patients to see police, judges, and other officials. We are often the only friends a patient has, and we don't consider it a waste of family planning time to help a friend with a problem. You'd be surprised at how much family planning you can work in while you are helping someone with another crisis.

No one is ever treated like a number. We try to remember the modesty, the dignity, the individual worth of each woman. Our clinics have a generally informal atmosphere. Things are often lively as well as slightly unorthodox. On clinic day, two or three staff members may be going about duties with a baby over the shoulder or a toddler by the hand while the mother is being seen. People just drop in. We have two retarded sisters who are patients who come in whenever they are in the neighborhood. One plays an imaginary guitar and sings "Country Roads" at the drop of a hat. We just work around our happenings. It may not look businesslike, but we do a lot of business.

In the early days of our program, our staff was on volunteer duty with other agencies a lot. We worked at food distribution centers, immunization clinics, assisted with a pilot tuberculosis screening project. Whenever help was needed, we went—and everywhere we went, we talked family planning. Every segment of the community was involved in getting family planning going, and they still feel pride in the program. Ministers, doctors, lawyers, patients, housewives, governing officials, and lots of others. Through hard times we once had to raise money, one month at a time, for 11 straight months, to pay the salaries of three community aides. The city, the county, and assorted friendly individuals helped out until the State Health Department bailed us out. We have used whatever resources were available, but always with the thought that the approval of the medical community and the community at large was of more lasting value than easy money. That is not an easy choice when money is involved, but many things must be considered.

During our development we have made use of Manpower Training Programs, the Emergency Employment Act, and always volunteer help. Our program was, in the West Texas vernacular, put together with baling wire, but through it all we kept growing, the patients kept coming, the doctors kept coming, and we kept an optimistic outlook. Because we were few, we cross-trained until almost everyone can do almost anything—and may have to.

The doctors who took care of our clinics were intrigued by the system and the team efforts. In a doctor-short area, we always managed to have doctors (and for two years we didn't have money to pay them). There are no prima donnas on the staff—any job is just something that needs to be done. Anyone who has ever been a housewife or mother has already experienced a certain number of unpleasant cleanup jobs. The doctors caught the spirit and have played stevedore in loading and unloading our van, have changed flat tires, and done an interesting number of other things when emergency demanded.

We have learned much from the community aides who either grew up in the neighborhood they work in, or in one like it. We have never lost a staff member to another job although several have had attractive offers. As a matter of fact, those same doctors who are otherwise so good to us, have been known to try to lure away an aide to assist him in private practice! Among our aides is a mother of 12, whose childbearing ended with a brush with death and a tubal ligation. She didn't know there was such a thing as family planning, but she is a crusader on the subject. All of our aides, and most of the rest of us, speak Spanish. For most, Spanish is the first language. Our ethnic makeup is chiefly Mexican-American, and we also have one black, one, plus one half-time employee Anglo-American, and one Chinese-American. We point out that she too is bi-lingual; it just happens that her other language is Chinese.

All of those who have contact with the patient make input to the record, and we rely very much on the aides for varied kinds of problem solving. Doctors and nurses have learned that a patient may whisper to an aide some pertinent information that they will not divulge to them. Aides assist the doctor in the examining room, and the last person the patient talks to before leaving the clinic is an aide who has heard the doctor's orders and who makes sure the patient knows every step in following them, and if she needs a follow-up appointment.

Of course, no matter how much the service is wanted or needed, and no matter how helpful the staff, the element of availability is necessary. We have been able to accomplish that in the communities we serve. Our clinics are within walking distance for most patients, save for those on remote ranches. Our headquarters office and clinic is in a Neighborhood Center in the largest barrio in Del Rio, the largest city we serve. Clinics in smaller towns are in community centers, schools, churches or whatever is available. Two communities have built examining rooms, equipped with examining tables, as part of their fire stations.

We haul our supplies and equipment in a six-year-old Ford van over more than 8,000 sparsely-populated square miles. The nurse and an aide or two leave at 7 a.m. in the van to arrive about 30 minutes ahead of the doctor and other staff needed for the clinic. We have had clinics in every kind of building imaginable—that means that first you probably have to get in there and mop it out! One of our clinicians was impatient with the time taken by a particular aide in wiping everything in the clinic room until the day she cleaned a black widow spider from the underside of his examining stool. Since then, he hasn't complained.

Our clinic room may be a community building kitchen rigged up as an examining site, but our medical services are those recommended by the American College of Obstetrics and Gynecology. We have a close working relationship with the famed M.D. Anderson Hospital in Houston, and our program has had some warm words of praise from visitors from their staff. Our chief clinician had special training there, and through their assistance we have been able to obtain the best of follow-up care and treatment for those of our patients who had been found to have cancer.

As Family Planning, Region 9, Texas Department of Health, we now own our desks and typewriters and no longer have to borrow or bring our own. Our Regional Director, Dr. Rodger G. Smyth, a Southwest Texan himself, recognizes the importance of keeping in touch with the community. We stay in touch with the city and county officials in the area served, and we let them know how we are doing and how much we appreciate what they have done for the program. We keep in touch with the HSA representative in our area, and let him know how things are, and ask his help in getting information we need. We stay in touch with the Council of Government officials on future plans and current accomplishment. We keep in touch with the schools—provide research materials and serve as guest lecturers in classrooms. We supply the county library with family planning and sex education materials and help provide leaders for the Methodist Junior High Sex Lab. During the past six months we have sought aid from one of the Catholic priests for literature on the Billings method for a fertility patient, and we loaned our projector to another priest to show films at the church. On a daily basis we work with the welfare department on common problems. The doctors send patients to our clinics. The hospital social worker calls on us for guidance or help. We still help out with the big immunization clinics, and we still get help from volunteers. The Housing Authority just gave us their old copy machine when they got a new one. One of the doctors brings along his cryo-cautery machine to use in our clinics. In rural areas everything is not available, and people rely on each other.

Before this year is over, we will have passed the 5,000 mark on patients. It is more than we ever anticipated. Federal and state funds support us, but the people still feel it is their program—born and bred in Texas.

Regional Health Department

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I am pleased to have been asked to give a few comments on the Southwest Van Family Planning Program. We've been most fortunate in hearing the star of that program which evolved to meet the needs of the border area around Del Rio. The reason that a person like myself, who was some 360 miles away from that border area—and until he came to Texas had never heard of Del Rio—got interested in it was because of my experience in working in overseas development with the Ford Foundation in India and later at the East-West Center. In that experience in working with rural development projects, it wasn't very often that we came across a well developed program that on almost any criteria was successful.

Finding a Model that Works

The presentation on the community based regional family planning model is composed of three parts: the identification of various inputs and how they are combined to meet a recognized community health problem, a view of how the service program operates, and the assessment of the factors leading to its success. Put more succinctly, what is involved is program structure, performance and evaluation of impact (Reynolds, 1973).

Before proceeding, however, it is necessary to consider the environment. Because the program operates in a rural setting, a number of constraints are involved. These affect availability of service, accessibility and adoption. Important constraints are lack of population density, lower economic and education attainment, more limited access to health service, and fewer resources to build and maintain a family planning service. All of these factors make it difficult to mount and sustain a program effort.

To accentuate the difficulties of program development further, the region selected is along the border in Southwest Texas—conservative, poor, and with a large population of Mexican ancestry. The situation is further exacerbated by a continuing influx of Mexicans. The first step in the search for a model was simply to identify a program able to operate effectively in such an area.

Structurally the Southwest Van Family Planning Program combines a central clinic facility in the major town of Del Rio with satellite clinics in various smaller towns. It uses outreach to extend its service accessibility. The staffing pattern represents the most formal aspect of organization, but it is also a strong indicator of growth. The Southwest Van Program originally had a regular professional staff of two, a medical and a program director, and both were volunteers. Its budget was $50. Today the number of positions is 14½ and each is state funded. The annual budget is close to $200,000 The staff include, in addition to the medical and program director, four cooperating physicians in the area, one and one-half nurse positions and seven outreach workers. The staffing pattern has remained at approximately the same level since 1972 when it received funding from the state. Administrative work has recently justified the addition of an administrative assistant for routine office management. The program presently operates in four to five counties and at a number of clinic sites covering a catchment area of 8,544 square miles.

In describing the scope of its functions the Southwest Van Program gave itself a broad mandate. As stated, "The aim of the Southwest Texas Maternal and Child Health Van Project's ongoing program is to provide comprehensive family planning health services with full community involvement." By comprehensive was meant a full range of preventive services in family planning care, health education, some medical care, and referral to other social and medical resources for conditions requiring further diagnostic procedures, treatment or services of specialists. By "full community involvement" was meant using all the resources available in the community—local medical personnel, volunteers, civic organizations, the schools, the library, local government, the media, lawyers, merchants, and the people to be served.

This population of women in need of family planning services was largely Mexican-American with 75 percent of the area's 68,000 residents having a Spanish surname. It was mainly Roman Catholic. More than a third of the families had incomes under $3,000 and all of the counties were well below the national family income average of $9,433 (1972 estimates). The median educational level was only 4.6 years for the Spanish surnamed population compared with a national median of 12.2 years. Forty percent of the residents of the group with a Spanish surname were under 16 years of age.

Approximately 2,066 women, ages 15-44 constituted the target population of the Van Program. Responding to this need, the program had on its rolls some 567 women by the end of the first year of operation. In 1972, 800 new patients were added. At last count the number of patients was well over 4,000 exceeding the program's original target estimate by a ratio of more than 2-1 and raising the intriguing question of the origin of all of the users of the service and of the communication process at work. 1,469 patients, a number exceeding the first year's total patient load, were seen during the first quarter of FY 1977 alone. Accordingly, the program can be considered to have responded effectively to a need, and that need seems to be both continuing and growing.

Why is the program working? David Korten in his provocative piece "Management for Social Development: Experience from the Field of Population" (1976) presents a series of three family planning program models: clinic based-clinician oriented, clinic based-community oriented, and community based-community oriented. As he states, "The major breakthrough normally comes when the community rather than the clinic becomes the actual focal point of program concerns and activities." What stands out first about the Southwest Van Program is that even from the onset of the program in 1970 it perceived the total community as its resource base. Further, this perception of the community went beyond the usual verbiage. It was a programmed and continuing function of management. There was a systematic review of the full range of resources which could help the problem in any way

These were listed, the people or institution contacted, and the needs specified. Dividing the community into providers, users, and potential supporters, all were utilized. The manpower pool included the local physicians hired on a fee-for-service basis and outreach workers or community aides recruited, screened, and hired from the communities to be served. The latter were all bilingual and representative of the culture. Lawyers donated free legal service; housewives provided clerical time to help the program.

Institutionally there were a number of local organizations which could be involved and were. They ranged from charitable organizations, i.e., the commissioners court and the mayor, and on a larger scale the regional development council down to the school and libraries in the local community. For example, in 1971 films were shown to 1,500 high school students in the schools. Given the touchiness of the subject this was a strong indicator of the community support. Community orientation was and continues as a hallmark of the program even though the early novelty of the program should have long expired. Further, the program's support outside the community base has grown. A second key factor appears to be the scope of the operation: policy options on services offered, i.e., abortion, contraceptive methods offered, MCH services, use of the private sector and community involvement; target population definition; new service facility location. As can be seen, the program was formulated along very broad and comprehensive lines. Its designation as a family planning program was interpreted by the staff to cover the full health of the family, to the extent feasible. As formally outlined, it included:

1. Preventive services in family planning care and the coordination of these services with other medical care programs.
2. A full range of contraceptive services including tubal ligation and vasectomies.
3. Provision of quality medical clinic services covering expansion to areas with no easily accessible services.
4. Health education programs including information both in Spanish and English on diseases and on other health problems.
5. Referral to other social and medical services for conditions requiring further diagnostic procedures, treatment or specialized services.
6. Evaluation.
7. Expansion to eventually cover the Middle Rio Grande Region.

In fact, to the extent feasible, it cared about the social, economic and mental health of the patients and their families.

This orientation had several important concomitants. The program structure was geared to foster a problem-identifying and problem-solving organization. If the problem affected the family, but was beyond the scope of the program's resources, either the resources would be found or the patient would be referred to that part of the local, regional, or state health system which could take care of her. The staff would often provide personal assistance. For example—taking a non-English speaking local woman to MD Anderson Hospital in Houston, 360 miles away, for cancer treatments. A consequence of this community and problem-solving orientation has been the continued growth and vitality of the local program. The patients are not viewed by the community aides as numbers on a reporting form but people whose human interest stories rival the "soap box" opera. As a result, these "outreach" staff, who have remained for several years, are just as highly motivated today as when they began with the program. Even though career advancement opportunities remain somewhat limited, they still experience the challenge of the work as they know they are helping their own community.

A third factor, and one which forms the parameter of the community based model, is the area of its operation. There needs to be a delimiter. The test is at what point does the community no longer identify with the program? Once this personal identification is lost, the supportive base in the community is correspondingly lost.

The fine line for the local program is to retain community identification yet with a capacity to mobilize sufficient resources to respond effectively to the problem. The county, as a unit of operation, is, in much of Texas, inadequate for this purpose. In recent years, especially since the social legislation of the 1960s, regional organizational mechanisms have evolved to broaden the local population's perception of community. For example, there are now councils of governments such as the Middle Rio Grande Council of Government which are concerned with the development problems affecting several counties. Although the counties still retain political power, experience with regional organizations have helped to facilitate people working together across county lines for a common purpose. Similarly, the Public Health Regions of the State of Texas Department of Health provide an umbrella for the delivery of public health services to a multi-county area.

The Southwest Van Program has operated under the aegis of a number of umbrella organizations—Planned Parenthood, OEO, Maternal and Child health, and Public Health Region 9. This has provided it with more institutional stability, i.e., legitimacy, funding, more positions than could have been afforded from local support except on a tenuous volunteer basis. As noted previously, an early orientation of the program was to a regional approach. Given the service need of other counties and its establishment as a Van Program, the coverage of its operation has extended beyond the central clinic facility in Del Rio to a number of clinic sites in Val Verde and surrounding counties.

The development of a similar, if less extensive organizational structure has allowed the program to tie into the existing local sources, i.e., facilities, physicians, political support of these other counties. Community identification with the program remains. But at some point a threshold will be reached either in distance, or time travelled, or program size, or extent of external support dependency when the community will no longer identify with the community and each other.

These potential thresholds furnish the constraints. The organizational aim is to retain the balance which allows for the community based regional model with its strong community commitment. At the same time support is needed which will not become dysfunctional to community involvement. A complicating factor in the determination of when the threshold is being approached which will change the balance is the continued growth in the program's own capabilities over time. The Van Program with two volunteer staff is not the Van Program in a fairly stable state with 14 or 15 personnel. This in turn would change if new personnel were to be added and would again be subject to modification if the area of coverage or the number of functions were to increase.

The final and perhaps most critical factor, assuming there is funding, is that of leadership of the community based program. Despite the ambiguity surrounding the concept, there are enough examples to illustrate clearly when it is present. Some problems in operationalizing the leadership concept are that it tends to be overly identified with the "person" rather than with the "functions" to be performed for the program to develop. Second, the identification of functions tend to concentrate on management tools, i.e., formal training in accounting, personnel, budgeting—which may be conspicuous by their absence among staff recruited in a rural setting.

What then is critical to the management function of a community based program in a rural area? The internal management of the program is obviously important—planning, setting objectives, establishing procedures, recruitment of staff, organizing and allocating resources, motivating and supporting staff, checking results, evaluation, and modifying to improve performance (Drucker, 1974, Korten, 1976). There are, however, certain other functions which are less well considered but have been particularly important in understanding the success of the Southwest Van Program:

1. The ability to develop and maintain lines of communication with sources of support in the community and in the bureaucracy, i.e., DHEW Regional Office VI as well as the State Department of Health; the State Department of Welfare, as well as the State Department of Health; and the Public Health Region as well as the Maternal and Child Health Division.
2. The ability to raise and sustain funding for the program, preferably from multiple sources.
3. The ability to protect the integrity of the program from the encroachment of other groups who seek to gain control of its jurisdiction, funds, staff, and facilities.

These are the organizational imperatives of survival, maintenance and growth.

The skill that each of these functions requires is the political one. The director of the Southwest Van Program has been particularly well endowed with these skills. But the individual person cannot be replicated. What is of interest is how the functions and corresponding skills needed can be replicated. In other words, do we have criteria which can systematically be applied to identify the program developer? The Van Program suggests the following quantifiable criteria in selecting a director for the family planning program capable of building and sustaining a program:

1. There is an established community track record.
2. Political ties are well established and a strong political base of support exists.
3. A strong value is placed on interpersonal and public relations.
4. The dedication and commitment of the individual and possibly, cosmopolitanism.

What is suggested by these points, abstracted from the Van Program's experience, is the need to develop an index, probably weighted, for testing leadership. Application can be by resume, reputation in the community as an indicator of political support and social standing, and on-site observation of physical and continuing evidence of the earlier work benefiting the community. Note that the various methods provide checks on each other.

What is of interest in this discussion of the leadership variable is that the local community, with all of its shortcomings—especially in formal management training—may represent the best source for obtaining the political talent needed to organize, build, and sustain the program and for insuring that the talent will remain in the rural locale. Short formal course training and/or on-the-job training can overcome the management deficiencies. But it is the political talent which is needed to concentrate resources, hold on to them, and build an adequate set of services each time.

Physician Referral Program

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I'd like to begin with a description of the area that my program serves and also a description of how a physician referral program works. From there I will look at the problems and successes that we've had, and the larger, more basic questions that these problems and successes suggest.

I am director of the Family Planning and Education Center, which is located in Berlin, New Hampshire (population 15,000) and serves the southern two-thirds of Coos county. Coos is the northern-most county in New Hampshire and it is also the largest (1,320 square miles). Population centers are separated by numerous mountain ranges and most of the population lives in small towns or rural farming areas. Each town is independent with its own life style, and its own political and philosophical views, and residents identify strongly with their own community.

Because of the mountains, travel and transportation are a considerable problem. The average snowfall in the winter is three to five feet and winter lasts from November to May (prompting the old saying that the North Country has nine months of winter and three months of poor sledding). Most of the roads are small and narrow, and steep notches separate towns and communities from one another.

The population is largely French Canadian and Roman Catholic. The 1970 census shows that 60.5 percent of Berlin residents claimed French as their mother tongue. This population is, for the most part, traditional in values and conservative in politics. The population is also predominantly low income. There is a high unemployment rate and much of the employment is seasonal. The major employers are Brown Company—a paper mill, and Converse Rubber Company—a shoe factory, and their hiring practices fluctuate with the economy.

Coos county, according to the latest Bureau of Vital Statistics report, has the highest percentage of teenage mothers in the state. A study performed by The Alan Guttmacher Institute in 1975-76 points out that 73.8 percent of the women in need in Coos county were not receiving family planning services at that time.

In order to understand family planning in New Hampshire's North Country it is important also to understand the physician community—for they are the ones who control the health care system right now. The majority of the physicians in the area are solo general practitioners. A high percentage of them are over 61. In fact, the percentage of physicians in Coos county who are over 61 is twice as high as the state average. In Berlin there are 1,807 people per physician—the state average is 696, and 24.3 square miles per physician whereas the state average is 7.6 square miles per physician. The fact that these physicians are older and are in solo practice means that they are extremely independent, individualistic and committed to the current delivery system. They are against government intervention and see federal programs as interfering bureaucracy.

There are no ob/gyns in the entire North Country, and New Hampshire law states that a nurse midwife can practice only when sponsored by a board certified ob/gyn, so there are no nurse midwives either. There are three younger National Health Service Corps Public Health Service physicians in the area, but they are regarded with suspicion and mistrust by the older physicians who make up the established medical community.

The Family Planning and Education Center is sponsored by a Community Action Program and began in July, 1975 with three part-time staff members: a director, outreach worker and bookkeeper. In July, 1977 we added another part-time staff member and opened another program site in Lancaster, New Hampshire, a town which is 40 miles away. Current staff now includes: (1) the program director who works 32 hours per week and is responsible for running the program, writing proposals, participating in statewide meetings and providing direct services; (2) the site coordinator who works 36 hours per week and is responsible for running the satellite office in Lancaster and providing all the direct service there as well; (3) the office manager who works 24 hours per week and is responsible for all records, inventory, billing and some direct service; and (4) the bookkeeper/secretary who works 12 hours per week and is responsible for answering the phone, typing and bookkeeping. Even though we only pay the bookkeeper for 12 hours, it should be noted that she is there full-time and Community Action pays the remainder of her salary. Every staff member except the bookkeeper does counseling and patient enrollment.

In FY 1977 the staff of the Family Planning and Education Center gave over 20 lectures or courses and served 350 active patients on a budget of $33,000. This allows a per patient cost of $95. Clinics in southern New Hampshire have per patient cost ranging from $65-$80.

Funding for the program comes from four sources: Title X makes up about 30 percent of the total budget; Title XX makes up about 60 percent of the total budget; Title XIX makes up about six percent of the total budget; and patient fees make up about four percent of the total budget. This year we also received $2,500 from the county and $1,500 from our own fund raising efforts which we use as match for Title XX.

The Family Planning and Education Center is a physician referral program (PRP). There are four PRP's in New Hampshire, all in the North Country, and each is run as a separate administrative unit. A PRP is a program in which all the medical services are provided by local physicians in their private offices, and all counseling and contraceptive supplies are provided by family planning staff members at the program site.

If a woman is interested in the program and comes to our office, we explain the program to her and the eligibility requirements. If she decides to enroll she then fills in the appropriate forms and receives a card which identifies her as a member of the program. At that time she also receives complete contraceptive counseling and an interim method, if necessary. The patient is then asked to make an appointment with her physician for a pelvic exam, Pap smear and method Rx. If she doesn't have a physician we give her a list of the local physicians who have agreed to participate in the program.

The Family Planning and Education Center has contracts with all physicians who participate in the program. In the contract physicians agree to provide certain basic services at a set price. We have three standard visit types: (1) complete physical includes pelvic, Pap, breast exam, hematocrit, urinalysis for which we pay $24; (2) physician revisit—could be pill, diaphragm or IUD check, IUD removal, amenorhea, break through bleeding, etc. for which we pay $10; and (3) IUD insertion, includes cost of IUD, for which we pay $30. We pay separately for Pap smears, VD cultures, pregnancy tests and other appropriate lab work. Once the patient has seen the physician, the bill for that visit would be sent to the Family Planning and Education Center and would be paid for by the program. The patient would return to the program site for her contraceptive method or further counseling and information.

This method of delivery, then, combines the idea of private medical care with a federally-funded program. We provide everything that a clinic can offer, but the services are split between the family planning office and the physician's office.

Why physician referral? We have found that the physician referral model seems to accommodate many of the idiosyncracies and difficulties of serving a rural population. One of the advantages is that a PRP does not require a large amount of front money to set up. You can begin the program with a minimum of staff. In fact, all that is absolutely necessary is a counselor, an office, a telephone, and the participation of at least one physician. There is no initial outlay for medical equipment and no need to look for the space to put a clinic. There is no need to hire doctors or nurses, and there is, in general, a greater acceptance of the program because local physicians are providing the care. It's a good way to begin providing services in an area where nothing existed before.

One great advantage of this system is that it does not take patients, i.e., income, away from the participating physicians. A PRP puts patients back into the established delivery system and guarantees payment to the doctors. Physicians often are pleased because some of their chronic non-paying patients become a guaranteed fee. One added benefit for the patient is that putting her in touch with a family physician may get her back into the health care system, and other health problems which have been neglected may be picked up and treated at the "family planning" visit.

In short, a PRP eliminates most of the physician hostility to the program by asking them to participate in a way that is not threatening to them and which, in fact, contributes to their private practices. A PRP is also less "government" in nature, and this makes it more acceptable to physician and patient alike.

For one thing, a family planning visit is the same as other health care experiences the patient has had. Patients in northern New Hampshire are not used to clinics or having a different physician each time they go in. It also helps preserve anonymity which is important in a small town. The patient can sit in the doctor's office along with everyone else, and no one knows what, specifically, she is there for. She doesn't have to park her car outside the Family Planning clinic on Wednesday night, or line up beside the mobile unit when it comes to town. This system provides as little intervention as possible into the existing medical and social structure.

Physician referral is also a convenient way to cover a large rural area when transportation is a problem. It cuts down on patient travel. The patient can see a physician who is nearby and she can choose a time that is convenient for her to make an appointment. She is not locked in to the one night every two weeks that a clinic might provide service. It also means that she can see the physician immediately if a problem arises and she doesn't have to wait until a clinic night. It means, too, that a woman can receive care in her own community from someone she knows, and this is often extremely important for people in rural areas.

The PRP, in short, answers many of the problems that we are faced with in rural areas, but it also leaves others unanswered, and it creates some problems of its own.

Despite the fact that a physician referral program is set up to accommodate the local physicians as much as possible, physicians are still a problem. Although they are not against the program, most of them are not strong supporters either. Their attitude is primarily one of tolerance. They will tolerate us if we don't bother them and if we continue to pay. (An indication of this attitude is the fact that one physician out of the 20 or so who participate in the program contributed to our fundraising campaign this year.)

The majority of the physicians who we deal with are interested in solo, private practice. They are not interested in changing the medical delivery system and they support the status quo. Even the group practice that we deal with in Lancaster is staffed primarily by older physicians who are not interested in innovative ways to deliver health care. These attitudes limit the growth of Family Planning and also the impact of Family Planning in the North Country. We have tried to deal with this problem by sending them information about what we are doing, how many patients we are serving, etc. We have sent out questionnaires to them, visited in their offices frequently and asked their advice on specific problems. None of these approaches, however, seems to have worked very well.

Combined with the problem of physician attitude is the fact that we have little direct control over the quality of medical care that our patients receive. We do present each physician who agrees to participate in the program with a set of guidelines for each family planning visit type, but there is not much that we can do if they don't follow the guidelines. We have one physician who prescribes the pill PRN, another who does not consider HBP a contraindication to the pill, and the type of pill prescribed often depends on what drug salesman has been there last.

We have tried to deal with this situation in two ways: (1) by educating the physicians in a non-threatening way; and (2) by educating our patients about what constitutes good health care. We have provided all the physicians with a copy of *Contraceptive Technology* and Rocky Mountain Planned Parenthood's new book, *Managing Contraceptive Pill Patients*, and we xerox and send out any articles which our staff has found interesting or appropriate. Most of the physicians, however, admitted that they don't read the material we send. We also offered to sponsor a clinical seminar on diaphragm fitting and IUD insertion since only a few of the physicians offer these methods to their patients, but the response was overwhelmingly negative—the prevailing attitude was "we already know that" or "we don't need to know that." We do have a physician who is medical advisor to the program, but he avoids any discussion which involves criticism of his colleagues. On the whole, I think our efforts to educate the physicians have had very little impact.

On the other hand, our efforts to educate patients usually work well. We have an advantage because we can take the time to explain to a patient why HBP is potentially dangerous or why she should have a Pap smear routinely. Once a woman understands the situation, she is usually willing to either change physicians or make some demands on her current physician. This needs to be handled tactfully, however, so that the physicians do not feel that Family Planning is trying to tell them how to practice medicine. This is certainly not the ideal situation, but it does provide a limited way of monitoring the care that Family Planning patients receive.

Another problem that we have experienced in delivering family planning services in a rural area is a sense of professional isolation and lack of power. The ruralness and uniqueness of physician referral in the North Country meant that we were often left out of decisions concerning family planning in New Hampshire, and also that workshops, training sessions and other support systems were not designed to meet the needs of PRPs. In 1975, none of the other family planning programs or other agencies in the state really understood what a PRP was, so decisions and regulations were made for clinic programs, and PRPs were supposed to comply as best they could.

Part of the problem was that program directors from the North Country rarely, if ever, attended statewide meetings because of the two to three hour drive which was necessary to reach the meetings which were usually held in Concord, the capital city. This meant that the North Country had minimal participation in state and regional planning concerning family planning, and it also meant that we had no political leverage when it came to decisions concerning funding, priorities, expansion or division of resources. There was also little communication between the PRPs themselves. We had no sense of power, no idea of how to effect change and no sense of being part of a larger family planning delivery system.

In the last few years much of that has changed. The four PRPs have formed a loose, informal organization called the North Country Family Planning Association which meets monthly. In those meetings we share administrative and management problems, exchange pills, pamphlets, films, etc. and make joint decisions about our role in family planning in New Hampshire. Other staff members can share the problems involved in counseling or outreach in a rural area. Last year the project director from Littleton organized a six week counseling workshop for the North Country programs which actually received funding from the regional training grant. We have recognized the fact that the rural programs and program staff have different needs in terms of training, bookkeeping, administration, management and funding, and we are beginning to deal with this.

Program directors from the North Country now make an effort to participate in all statewide and many regional meetings. We have raised the consciousness of the other program directors so that the physician referral viewpoint is now represented and even the regional office is soliciting our reaction to different standards and definitions that they are developing. There is also now a member of central New Hampshire Family Planning staff who understands the rural programs and is an advocate for our viewpoint at the state level. I feel that this has been a crucial change and something that rural programs must be aware of. In order to be effective we must participate in family planning at the service delivery level. The difficulty is that we pay a price for this participation. Attending these meetings takes a great toll in terms of time and travel. What may be a meeting of a few hours for some becomes a full day meeting for us because of the travel involved. It is difficult to balance our priorities because we are also direct service providers, so time away from the program may also mean that patients don't get seen.

Another problem that we face, which I think is common in physician referral programs, is that our programs cost more than the larger clinic programs in the more urban areas of the state. A PRP costs about $95 per patient and the clinics cost $65-$80 per patient in New Hampshire. The fact that the program costs more is usually the first and only factor that fundors consider. I feel it is important that we begin to change the way that the public in general, and fundors and legislators in particular, view rural programs. It is time that rural family planning people begin to develop criteria for rural programs which fundors can use to make their judgments on, instead of using urban programs as the benchmark for funding.

Perhaps there are some ways, though, that we could cut our costs too. One of the ways may be to join PRPs under one administrative unit. As it stands now each program has a director, each program writes a proposal, each program raises their own match. A lot of these administrative responsibilities could be combined under one unit to relieve the burden from local programs without removing the individuality and local nature of those program sites.

Another solution might be to have clinics in the population centers and maintain PRPs for the outlying areas. This might cut down on the cost of service. It might also help insure a higher quality of care for our patients, but this alternative also raises many problems in terms of the medical community.

On the whole, the physician referral model handles the problems of delivering family planning services in a rural area quite well, and we have found it to be a very workable model. A PRP deals with the problem of distance, travel and small towns which are idiosyncratic in character and independent in nature, it makes use of the existing man and woman power in an area of limited resources, and it attempts to fit in comfortably with the existing patterns of the medical community. The problem is that the model is only as good as the physicians who work in it. Some of our physicians are supportive of the program and are also fine clinicians, and with these physicians I think the PR model provides a workable way of delivering family planning services in a rural area. The majority of our physicians, however, aren't that good, and this weakens the effectiveness of the model. This fact also raises a basic question in my mind about what the role of family planning in rural areas should be: are we there to fit into the existing structure, to accommodate the status quo and to provide what services we can (because anything we can do is better than what was there before), or are we there as change agents who are demanding a certain kind of care and a certain quality of care for rural women and who are advocating patient education, preventive medicine and government subsidized health services? If it is the latter, then much more time, money and energy must go into rural family planning efforts. If we are going to risk challenging the status quo, then we must be certain of success. This would require much more support from state and regional sources in terms of money and coherent workable plans and policies for rural areas.

I think that it is time for a new kind of rural family planning effort. It is not enough for us to know how to relate to the rural poor and set up a program accordingly. I think it is time for those of us involved in rural family planning to take the initiative at the local, state and national level. We need to make the concerns of rural family planning more visable, we need to be active on the political levels where the decisions concerning funding and priorities are made, for without this kind of effort rural family planning programs, in my opinion, will continue to play a secondary role to the urban programs which are more visible and packaged to sell.

Domestic Perspective

JAMES L. REITZ

Area Manager
Family Planning Council
of Western Pennsylvania

About seven years ago when I was asked to start a family planning program in rural Indiana County, Pennsylvania, I first visited four or five apparently successful rural programs to learn what they were doing and how they began. From that point, my interest in hearing the stories of how rural programs began and some of the seemingly insurmountable odds they faced at the outset, has never subsided. Through the Rural Committee of the National Family Planning Forum, through assisting with a number of rural training workshops and in gathering information for the book on Family Planning in Rural America, I gained many more opportunities to hear of and read about rural program histories. As I listened to these papers today, I was conscious of a "common thread" that seems to run through most of these accountings; it might be phrased something like this: "*You wouldn't believe* the conditions we had to deal with and the problems we had to overcome to set this program up and keep it alive." In a very real sense they each seem to be saying, "Our program must be the most unique and have the most unusual history you have ever heard." And I could honestly respond to each of them by saying, "You're absolutely right, I've never heard a story quite like that before."

There is a fascinating uniqueness to each rural project, yet out of these uniquenesses we can also find some commonalities which should produce useful learning for all of us.

A conference like this is faced with what on the surface might appear to be a paradox, but really is not. On the one hand, I think we need to honestly ask and attempt to answer the question, "*Is* there anything significantly, importantly, unique about rural family planning as compared with our urban counterparts?" On the other hand, the Conference is searching for common or shared concerns, problems, needs, strengths, insights, etc., upon which to build.

So, as I respond to these papers we've heard, I'd like to focus on two kinds of facts. First, ways in which rural programs are significantly, importantly and *necessarily* different. I should explain my use of the word necessarily. I sometimes get the impression in talking with personnel from large, long standing, urban programs that the main reason our rural programs are different is more a matter of size and age, and when they get larger and have been in existence longer, they'll do most things about the same way as urban programs. Contrary to such an implied assumption that, "When you grow up you can do things like the big folks," I'm saying some things are necessarily different about rural family planning.

The second kind of fact I'll focus on is evidences of developing solutions to common problems. Let me start with the question of what is unique about rural family planning and see what our speakers have told us in that regard.

1. The options are less.

Several of our speakers stated directly that in rural areas your service options are less. For example our speaker from New Hampshire compared the physician to patient ratio and found 1,800+ to one in her area and 700− to one in the state as a whole. In many, perhaps most, rural areas, if you don't like your present MD your only other option is "no physician."

Primary care clinics are less common, and hence less an option, in rural areas. However, under the stimulus of RHI (Rural Health Initiative) funds, and HURA (Health in Underserved Rural Areas) and using NHSC (National Health Service Corps) physicians, this is changing. I think this is an encouraging prospect for the future in rural health care. But, in general, I agree. Your options are less in rural areas.

2. Lack of anonymity.

The difficulty patients, especially minors, have in attending a family planning clinic without encountering someone they know can be a major barrier. In one Pittsburgh city clinic the chances of a woman being recognized as she goes in a building which houses many offices and takes an elevator to the twelfth floor which has several offices, is very slim. In most rural areas the chances of *not being seen* by someone she knows are very slim. We have to find ways to neutralize this problem.

3. Demand of a broader range of services.

Sheri Tepper called this the problem of "creeping service." Rural programs are pressured to see patients who do not meet funding guidelines and to give services which are not reimbursable to us under Title X, XIX or XX. It cuts into staff time, increases cost per patient and increases waiting lists for patients seeking appointments. But the needs are very real. The appeals for stretching our services are very poignant.

4. Political factors—legitimizing—affect service delivery.

It is easier to get shot down in a rural area if you don't follow the right protocol with informal and formal leaders of the medical and general community. There are ways to deal with these factors, but that is the point. It burns up energy, and sometimes a lot of time, to make sure you do deal with these factors appropriately.

5. There is often high dependence on interrelationships with other agencies and services.

If there is only one hospital in town, only one lab, etc., you are in a more dependent position. It is possible, but unlikely, that the program will be largely successful without a good, or at least adequate, or at least non-antagonistic, attitude on the part of the health department, county welfare office, school system, etc.

6. Costs are greater.

The major factor in a family planning cost ratio is the denominator. (Costs divided by number of patients.) The numerator would be equally important if you had the option of making it as low as necessary to fit the number of patients served, so the result came out a nice defensible figure that would make our fundors smile. But we don't have that option because no matter how small the program, there is a level of cost for staff, and all the rest that you can't drop below if you are going to run a program at all. If patient census, patient density are low, costs are going to be relatively high even without adding in the extra costs of outreach, transportation and "flying in physicians" as we heard of today.

There is a lot more that could be mentioned under rural uniquenesses, but time doesn't allow us to get into roads and weather, cultures and customs, values and geographic barriers. I want to move on to the second kind of facts, a set of facts that happen to be very important if all of this is going to be of any help to anyone. What commonalities of approach to solutions, to use of resources can we detect?

1. Rural people are mobile in their own ways and patterns.

I think every speaker made this point in a variety of ways. It is true that there is almost no public transportation in rural areas and that getting to the clinic can be and is a significant problem. But, it is also true that rural people do get to shopping areas, centers where health, welfare and other service agencies are located, and to school, church and entertainment locations. They have patterns of mobility, discernible patterns and, I'd like to believe, patterns of which we can make use. If our rural programs can deal with communicating the what, where and why of the program to the people who have a felt need for it, transportation will be less of a problem.

2. You can and must choose from a variety of service delivery modalities.

In the book on rural family planning, I was able to describe at least seven significantly different rural service delivery systems. What I heard from these speakers today was, don't assume how to deliver services in your area, or a new area. Pick the system or adapt the system that best fits the circumstances. In some instances, we may find it cost-effective to operate more than one system simultaneously in the same area, designed to reinforce each other. I think especially of the physician referral and central clinic systems.

3. Cost need not be great.

We listed "costs are greater" as a uniqueness of rural programs. Yet we can also agree, I think, that rural program costs need not be unreasonably great. Rural programs can be and are cost-effective.

4. We need to focus more on cost-effectiveness than on costs.

One of my not-yet-alleviated fears, I hope unfounded, is that as costs go up and the federal and state funds don't, or at least don't go up enough, resulting in a decrease in real dollars available, states and regions and councils will look around and say, "We could serve three women here in our large urban program for the same dollars that serve only one or two in that small, rural program; we can't justify keeping it open." I think we have to derive separate funding formulas for rural areas and/or focus more on meeting percentages of women in need in a given area than to look at just total dollars spent.

5. Developing use of "allied health personnel."

I used the phrase allied health personnel because I like and agree with Sheri Tepper's suggestion that it is more than just learning to make good use of nurse practitioners. We need to develop and make acceptable other medical specialty roles so that even the nurse practitioner is not tied up doing routine work which someone with less formal education and training could do and perhaps even be licensed or certified to do. Cappie Harper, director of the Women's Health Project here in northeast Georgia, has had some good experience with expanded roles of nurses.

6. There is value to a larger project base.

I may be reflecting a bias because I do work for a council which has funding and management responsibilities for 23 counties, but I detect the same message from several of our speakers today. Small, individual, rural projects simply cannot afford such useful management items as data systems, cannot afford to bring in physicians from outside the area, cannot afford much, if any "risk taking" if a trial delivery system in a given area does not work out. Some form of inter-relationship of rural programs in an area, and many forms are possible, can greatly increase each program's options—a problem I alluded to earlier.

At one time each of the 45+ family planning projects in Western Pennsylvania had its own director. About four years ago the Family Planning Council of Western Pennsylvania established an area manager system. Prior to that I was the full-time director of one countywide program. The job seemed to overfill my time. When asked to start and manage another program in a neighboring county, it seemed like too much. Yet, only four months after that when asked to also manage another project in a third county which had four clinic sites in three counties, it somehow didn't seem too much to ask. That job expansion continued until I reached the point of managing 11 clinics in seven counties. These were totally separate projects with, at that time, no interrelationships. In almost every case, staff at any one project had never heard of, much less visited, any of the other projects.

Obviously such a job expansion forced me to relinquish many non-management roles I had been performing and bring to each project only management attention, and hopefully skills, in areas of budgeting, staff utilization, site development, and overall policy matters.

This management pattern allows some staff sharing, the use of complimentary and different delivery systems within a larger geographic area, shared in-service training, valuable opportunities for staff of one project to visit and learn from procedures of another clinic, and I cannot count the times I've walked into a project office to be greeted by a statement such as, "We've got an awful problem." After listening I can frequently say, "We encountered that last year in the next county and here is what worked." The bottom line perhaps is that the number of patients served in each of these programs has grown steadily over the past several years and the cost of services has declined to the point of being very competitive with even large urban programs.

Conclusion

I believe this Conference can provide an important thrust in several ways which will promote the delivery of family planning services in rural areas. I'd like to conclude by mentioning some of the actions I'd like to see happen post-Conference.

It was only a few years ago that the rural committee of the National Family Planning Forum was formed. As Chairman for three years, I spoke with many rural project leaders from every region of the country and consistently got the impression that most of them had almost no awareness of what any other rural project was doing. Every idea, innovation, procedure developed was a "discovery." That shouldn't have to be.

1. Record and relate rural patterns.

So first of all, I'd like to see a large scale documentation of what is happening in rural areas. How many mobile units are being used? Five? Fifty? Five hundred? How many physician referral systems are there? Where are they? What generalizations can be drawn from them, especially those which, judged by most standards, are highly successful? Let's find out what we already know, what we've collectively already done, what is happening, what is working, compile it into a useable fashion and get it out to people who can and will use it.

2. A second rural conference or series of conferences.

I would like to see, probably on a regional basis, a series of conferences held for rural projects. Rural projects commonly have little or no money in their budgets for out-of-area travel and conferences, therefore, most of the cost of such conferences should be picked up by grant monies. Rural projects also have few staff and someone needs to "mind the store." If held on a regional basis conceivably there could be a day for administrators, a second day for nurse practitioners, nurses and other medical personnel and a third for outreach, education and other staff. The purposes would be two-fold—both to increase their awareness of what is happening and could be happening in and through rural programs and to learn from the participants what is successful and why.

3. Promotion of allied health personnel.

Working with such potential allies as the rural section of the American Medical Association, develop and promote accepted health roles which allow maximum and most efficient use of physicians and nurse practitioners. The only solution to the fact that rural areas are medically underserved is *not* just to somehow bring in more physicians. An option is to reduce what physicians have to do and thereby greatly expand the number of patients for which they can realistically maintain overall responsibility. Rural programs generally are dependent upon the more affluent urban programs and regional training centers, like this one in Atlanta, for development of materials, fiscal systems, data systems, etc. But we've been forced into the front lines of development and risk-taking in the area of use of nurse practitioners simply by the lack of any other ways to deliver services. In Indiana, Pennsylvania during fiscal 1977, 2,700+ patients were seen and only nine percent of the new patients and less than one percent of the annual patients were seen at all by a physician. If they *had* to be seen by a physician, the patient load would quickly drop to about 600 or 700 a year. A new nurse practitioner certification process enacted by the state could seriously hamper our ability to continue such use of nurse practitioner in rural areas. We need lobbying help, political help with such matters.

I congratulate The Alan Guttmacher Institute for establishing this Conference. I am grateful for the contributions to me personally and to rural family planning, in general, today's speakers have made. I sincerely hope what is happening here for rural family planning is only a beginning.

International Perspective

ALLAN ROSENFIELD, M.D.

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I come to this Conference with a personal perspective of some 11 years of internationally-oriented work, seven of those years living overseas in Asia and Africa. I found the data this morning most interesting..., particularly that some 56 million Americans live in rural or nonmetropolitan areas. This is larger than most developing countries in which I've been involved, although we usually think of the U.S. as a country made up of predominantly urban inhabitants. I was particularly struck by the number of similar problems (and solutions) that exist in rural America and in rural areas in the developing world, and I'd like to discuss some of these similarities.

One speaker this morning mentioned that most services were provided through state or county health departments. In the developing world the vast majority of providers in rural areas also come from federal or local health departments. Private practitioners, wherever, do not wish, for a variety of reasons, to work in the rural areas.

Second, all speakers this afternoon emphasized the importance of community involvement. Unfortunately, most programs do not succeed very well in actually effectively involving the community. Most, instead, are centrally planned and centrally implemented. The best example of true community involvement, perhaps, has taken place in the People's Republic of China. While they did set most major policies centrally, a significant degree of decentralization occurred in the planning, and, more particularly, in the implementation of programs. That country, as many of you know, has made a dramatic leap forward in 25 years in a variety of social sectors, particularly in health and family planning.

Third, there was discussion about the integration of family planning into other relevant programs, if they're available. This was particularly mentioned in the region nine program in Texas. This included not only health programs but non-health related programs. Efforts abroad have not been as successful, but there have been attempts to integrate family planning with malaria programs, other health programs, school programs, adult literacy programs, agricultural projects and others.

In the presentations on outreach efforts, there was some debate concerning the use of a mobile clinic facility versus mobile services utilizing any available location. We heard about the van that broke down after only one visit, and I'd like to relate a similar problem that we found overseas with the concept of a mobile clinic. International Planned Parenthood Federation (IPPF), at a relatively high cost, purchased large, elaborate, sometimes air-conditioned family planning vans to work in rural areas in Asia. They didn't have four-wheel drive, the axle was very low, and they couldn't maneuver any of the rural roads they were meant to drive on. They were painted white and eventually were called "white elephants." Far more effective is the concept of making use of a classroom, a church, or a village headman's home, and come out with a jeep or some such vehicle with the staff and the equipment needed.

The importance of the support of the church was mentioned in rural areas of the U.S. Similarly, religion has been of much importance in some developing countries, sometimes against family planning, but also sometimes very supportive, even in some of the Catholic countries. In some Latin American countries and the Philippines, for example, many clergy, particularly younger members, have actively supported family planning activities. In Thailand, Buddhist monks, in one experiment, have been actively involved as village contraceptive distributors.

Some speakers talked about language problems, particularly for Hispanic or Francophone patients. In developing countries there are similar problems in that often providers may speak the national language, while the people they are serving may speak a local dialect and not understand the national language. As in the U.S., the providers often don't make any effort to learn those languages.

A model similar to the physician referral program mentioned in Berlin, New Hampshire, was used in very successful family planning programs in Korea and Taiwan. In another talk there was mention of the commercial sector and its effectiveness in getting products out to the people. In 11 years of visiting extensively in developing worlds, I have rarely been in a village that didn't have Coca Cola, and usually also Pepsi. If the distributors can get these bulky commodities out, often over roads that really don't even exist, then we should be able to distribute condoms, oral contraceptives and various medications by making use of some of these commercial channels. Unfortunately, in general, we haven't, but rather attempt to create new distribution channels which usually don't get anywhere near the village level in the developing world, and I expect that the same is true in the U.S.

I'd like to spend the remaining time on an area of particular interest to me, one that relates to the effective use of a variety of types of personnel. I should state that as an ob/gyn my perspective in this area has changed significantly since my training, largely as a result of my years spent abroad. The report from Berlin mentioned that because there was no obstetrician, they could not use a nurse mid-wife. That is a surprisingly short-sighted, impractical and inappropriate attitude, but perhaps expected on the part of much of the medical profession. In cases such as this, where the decision lies between no care and care by someone other than a physician, the decision often is the former.

In the U.S., medical training is crisis-oriented, medical center-oriented, and specialty-oriented, with little attention to preventive aspects of care, or even to simply primary care. Senator Kennedy stated in an address that, "We do an excellent job of teaching physicians to take care of a few people, and a very poor job of educating physicians to take care of most people." Professor Robert Wright of Johns Hopkins, a physician with extensive experience overseas, has written about the immorality of the American health care system. He argues that a moral health system is one that "addresses itself to the major needs of the people, places major emphasis on health maintenance, provides available health service to every citizen on the basis of need, regardless of other considerations, is organized to provide a reasonable value for a unit of cost, satisfies the needs of the people, and does no harm." He reviews these characteristics, and he finds medicine in the U.S. falling short on all points.

There was a discussion about the doctor/patient ratio. In the U.S., in general, there are 700 people to one physician. In New Hampshire we heard of a ratio of 1,800 to one; in Central Harlem it is 3,500 to one. In developing countries the situation is far worse. In Thailand, for example, a country of about 42 million people, nationwide there are 7,000 people to one physician. But 60 percent of the physicians live and work in Bangkok, a city of three million people, leading to a ratio in Bangkok of 1,000 to one. Outside Bangkok there was one doctor for 35,000 people, but most of these remaining doctors worked and lived in other major cities. Thus, although almost 85 percent of the people live in the rural areas, most doctors are in the cities, with the result that in the rural areas there are approximately 110,000 people per M.D. If one follows the standards that states that only doctors are competent to provide care, what one actually does is deny care to the majority of people.

I have been asked, "Is it ethical to allow a variety of lay and paramedical personnel to provide various services?" I believe the question should be rephrased, "Is it ethical for such personnel *not* to be trained to provide care?" One might say that it is unethical to deny the possibility of care. Training is the key; we can train a wide range of people to carry out a variety of preventive and curative procedures.

In the past, physicians in the U.S. have questioned the use of mid-wives for delivery, although such personnel have performed extremely well elsewhere, such as in Great Britain. I suspect that in a carefully controlled study, mid-wives, with appropriate training and backing, would compare most favorably to most private practitioners and might even have lower neonatal morbidity rates, since they are much less likely to induce labor early or to use forceps earlier than necessary, either for doctor or patient convenience. In recent years, there has been a growing acceptance among the U.S. medical profession of more effective roles for various other members of the health team, including mid-wives, nurse practitioners, the MEDEX, etc. Interestingly, in reviewing several studies comparing mid-wives or nurse practitioners with physicians in the insertion of IUDs, there were none in which the nursing personnel had a higher complication rate. Further, in all the studies the mid-wife's continuation rates were all slightly higher than the physicians.

Overseas, in developing countries, there have been several exciting examples of the use of other providers. The barefoot doctor in China is perhaps the most frequently mentioned example, and he or she is usually a local farmer who receives two to 12 weeks of training. They then continue to work at their basic activity, and, in addition, provide the initial contact for primary care. According to a number of reports, they do extremely well at providing simple services. China has also given effective and rational training to all other levels of the health care system. The Chinese, in their desire to "serve the people," particularly in the rural areas, have elected to provide the best care possible to the majority of the people rather than providing only specialized services to a minority of the population.

One of the most dramatic examples of the successful use of non-medical personnel to provide medical services occurred recently in Bangladesh, a country with acute shortages of physicians in rural areas. A British trained general surgeon returned to Bangladesh at the time of their "war of liberation." He became highly motivated by the problems he saw and he decided to establish a health care system in a rural area outside Dacca. There were no trained health personnel in the area, so he simply recruited some village women and men and trained them, on the job, to provide a range of services. Among the various health services offered were family planning services, including minilap tubal ligation. He trained these people to help him in the operating room, initially as instrument nurse, then scrub nurse, and then first assistant. After a period of time, some of these women became the surgeons, initially with a physician assisting and eventually on their own. At this point, he compared the postoperative morbidity between this group (a total of seven women were so-trained) and two physicians. He found a lower complication rate among cases done by the paraprofessionals than in cases done by the physicians, and two of the seven women were illiterate. This is as good an example as any I know in showing that we can train a whole range of people to do simple, repetitive procedures, and we can train them to do them well and safely. Physicians must accept the fact that other personnel can provide good care and that these personnel should be thought of as equal members of the health care team. The Chinese talk about the "demystification" of the physician. Physicians are specially trained to serve as consultants, to provide care for complicated cases, etc., but need not provide all care. In many of the more routine and repetitive jobs, others may well do the job better.

The task facing us all, both here and abroad, is to provide the most effective services as efficiently and as patient-responsive as possible. We should involve the community in planning and implementation. We should provide effective training. We should develop relevant job descriptions for people involved in the program. We should make the most effective use of physicians and of other members of the health care team.

I very much have appreciated the opportunity to hear about the exciting rural programs in the U.S. The experiences described by the speakers demonstrate again the mutual learning that is possible from a variety of programs both abroad and in the U.S. I'm now involved in an urban program in upper Manhattan which is also a very poorly served area, and we are attempting to use many of the approaches discussed today. As Mr. Margolis stated at lunch, the urban and rural slums have great similarities. Both are grossly underserved. Our goals are the same: to improve the services, to reach the people in collaboration with the people.

Discussion

QUESTION #1: I was in China recently, and this story is a little ironic. We observed a tubal ligation done under acupuncture anaesthesia, and it was very impressive because the woman lay awake and talked to them during the operation, then afterwards she got up from the table and walked out. This was all very impressive, certainly for some of us non-doctors who haven't seen anything like that. So then we got back into the conversation with the hospital officials, and we were very interested in the acupuncture procedures, and somebody asked the question, "Is it possible to learn the acupuncture points for sterilization alone?" In other words, the question is really framed against some problem with the L.D.C.'s. Could you teach a family planning worker how to do acupuncture for sterilization alone? And the answer came back, "Well, there are particular points, but it would be much better to learn the whole system, because otherwise you'd be just a technician." So, there is sort of a creeping professionalism, and it may be difficult to fight it.

QUESTION #2: I just want to comment. You know, a lot of us would agree to use nonprofessionals. But how do we change the state laws? Recently, some doctors in the community would not use a practitioner because insurance companies would not handle the malpractice.

DR. ROSENFIELD: I think this is the most difficult problem, but changes are taking place. If you look back 10 years, we didn't have nurse mid-wives delivering babies or inserting IUDs in this country. Prior to that, many hospitals would not allow nurses to start an intravenous drip. These are now allowed. Perhaps the most effective way to start is to initiate pilot studies to demonstrate the feasibility, the safety, etc., of a new approach. Carrying out such an activity in a medical school setting may help to get it accepted more rapidly. There is a need to review some of our laws, particularly in this country, in regard to the malpractice situation. Progress can take place, and it is through people like yourselves applying pressure that change does start. Admittedly, however, it is not easy to get the medical profession to change its standards.

QUESTION #3: I just want to comment on what Dr. Rosenfield said. It's a cyclical kind of thing, because 20 years ago in urban Maine nurses were inserting IUDs, and it can be turned around. It's a matter of physician availability.

Dinner: Local Needs and National Responses

Remarks

JEANNIE I. ROSOFF

Vice President
The Alan Guttmacher Institute

I was thinking during the Conference that there was a kind of snobbism in reverse going on here. Usually you go to places and people say, "Well, the place I come from is bigger than yours." In this case, I think everyone is saying, "The place I come from is *smaller* than yours!"

I have heard that Rising Star, Texas, has a population of, am I right, 1,407? Or just about? And I know that Red Bull, Montana, has only 84, and I think or suspect that the reason there is no representation from Plains in this meeting is that between taking care of the big store in Washington and small and medium size stores in Plains, there was nobody left at home to send to this Conference.

Now, I start with an inferiority complex, because I come from Paris. It's a place which has a lot of trees, and it's green, but I don't think it will exactly qualify as a rural area. As a matter of fact, there was an old song, I think from World War I, that said, "How can you keep them down on the farm after they've seen Paree?" So, I think we would disqualify it as a rural place right there. I want to point out, because there is a game of one-upmanship here, that Paris is smaller than a lot of places: Mexico City, Tokyo, Moscow, London, and New York, that most evil of all evil places. Now, so you won't hold it against me that I come from a place that is somewhat larger, I think we shouldn't hold it against our speaker that she comes from Little Rock, Arkansas. I think that there are even more trees there, and there are trees all around the city and in the Ozarks and piney woods and so on. Even she will admit that Little Rock is smaller than Paris.

So, this is the first point we shouldn't hold against Carol, and the second thing is that Carol came to work for our office as a direct referral from Richard Nixon. Now the way it happened is, I think, they both took decisive measures and tried to get out of each other's way. Carol was working in the office of Congressional Liaison at HUD when Mr. Nixon won the 1968 election, and if he had found that she was still there when he got there, he would have gotten rid of her, and I think wisely so. But she was wise enough to get out of the way first, and she came to work for our office then. She worked for us for about three and a half years, and then she went to continue, pretty much, some of the same line of work at the Presidential Commission and then the Citizens' Committee on Population and the American Future. From there she went to be the executive director of the Consumer Federation of America.

When she went to the Consumer Federation of America, I think that her talent for organizing really flourished, so much so that when she was nominated for Assistant Secretary at the Department of Agriculture, some of the people in the agribusiness community decided to see what they could do about it. Fortunately I think, for all of us, they were not successful, and Carol did become Assistant Secretary of Agriculture. I personally would have preferred that she would have become Assistant Secretary of Health, but she went to Agriculture instead, and I think it is a worthy cause, too.

When I came to Washington there used to be jokes in our office if I disappeared for too long in the direction of HEW and one heard loud noises in the distance, it was that finally I had lost my temper, and surely set a small explosion in the building. From time to time on a quiet day, on a clear day, when I hear a little sputtering in the distance I dream that Carol is there in the Department of Agriculture setting off little, bitty explosions. At that point, I feel all is well. Carol is alive in the Department of Agriculture, and the department will be better for it.

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CAROL TUCKER FOREMAN

Assistant Secretary for Food and Consumer Services U.S. Department of Agriculture

Following Jeannie's introductions are always a demanding thing. I'm delighted to be here. Jeannie said that my appointment as Assistant Secretary of Agriculture was treated with some hostility in some quarters, and that's true. There are a lot of people who didn't think that I was qualified. To the extent that qualifications for the job are set by people who have held it in the past, that's probably true, because if there's one thing that I'm not, I'm not like my predecessors. I've never been a farmer. I've never collected price support payments or that sort of thing. I don't have a degree in Agricultural Economics. That bothered a lot of people, because you need a degree in Agricultural Economics if you're going to run the food stamp program and the school lunch program. I had never worked for an agribusiness corporation or for General Mills or for General Foods, and, furthermore, none of those people have approached me about offering me a job four years from now. More importantly, I wasn't a man.

All of those things made me very different from my predecessors, and you can understand, given all those differences, why all those people were concerned about me coming to the Department of Agriculture. Some people were substantially more than concerned. Earl Butz was furious. They told me when I came to the Department that I'd have to stop using four-letter words. I told them fine, as long as they didn't make me give up the ugliest two four-letter words that I know—Earl and Butz. Earl Butz said my appointment was an insult to the American farmer. That bothered me. If somebody else had said it, it wouldn't have bothered me very much, but for Earl Butz to say it, it bothered me, because we all know that he knows more about insults than almost anybody else there is.

All of the things that cause those people concern about my appointment to the Department of Agriculture were precisely the things that made my appointment by President Carter and Secretary Bergland a certainty. They obviously wanted me to change the Department of Agriculture, and there has been a change at the Department of Agriculture! Secretary Bergland likes to recall that when Abraham Lincoln created the Department of Agriculture over a hundred years ago, he liked to call it "the people's department," and, obviously, over the past few years it has gotten away from that description. It has come to serve a rather narrow commercial section of agriculture. It has been Bob Bergland's intention to move it away from that image and try to return it to the people's department, to make it serve as many people as possible, to have a department that reflects the concern of those people who consume food as well as those who produce it and to have a department that reflects the needs and concerns of urban people and rural people. Obviously, that's a change from Earl Butz's Department of Agriculture.

I can't think of a better way to describe that change than to tell you very briefly about a weekend I spent away from home last month—and I don't give up my weekends at home willingly. This one was kind of worthwhile. The Secretary asked us to invite 10 or 12 people who we knew for a weekend in the country who could comment in detail and with some expertise on the various programs in the Department of Agriculture. We had a magnificent cross section of experts. There were people from the agribusiness accountability project that used to attack large agribusiness firms, and there were some of those people from those firms. We asked them to do nothing over those two days except to talk to us about what the role of the Department of Agriculture should be and to give us their ideas about anything remotely concerned with food and agriculture. We asked them what we should be doing and even if there should be a Department of Agriculture. We got lots of ideas during that time. The field of rural development was very heavily noted during that weekend, and the theme that seemed to be most recurrent during the time we were there is that the Department of Agriculture needs to regain a sense of social purpose.

After that weekend, Bergland was making a speech, and he said that after talking to those people he realized that what the Department needed to do was to work on those problems that make people cry. He doesn't think, and I don't think, that that means that we have to abandon our traditional concern with farmers, because anybody who has watched a crop fail knows what it is to watch people cry. But it also means that we are trying to deal with a broadening of the mission of the Department of Agriculture, to go beyond farming to the problems that are just as important to the mission of the Department as it's carried out today—to the issues of human nutrition; to the issues of domestic food assistance; to the issues of concern to rural people; to improving housing and education and health care for rural people. Those, I think, were all issues that Bob Bergland was concerned with when he first came to the Department of Agriculture, and, as a result, he appointed someone else who was quite different from his predecessors. He brought in a gentleman by the name of Alex Mercure to be the Assistant Secretary for Rural Development at the Department. We've had a Rural Development Act in this country since 1972, but there hasn't really been a Rural Development Policy, and the law just kind of "sat there" over the past five years. Now the President has said he wants it to become an active law, and Alex Mercure and his people in the Rural Development Administration are hard at work on doing that. The act has been funded, and I think you are going to see a different kind of approach to the problems in rural areas.

The Department of Agriculture is going to see if the concepts that have worked very well in well-to-do rural areas can be translated into programs that will assist people in traditionally poor rural areas: the use of cooperatives, the use of planning agencies, remedial education, and job skill training.

I think it's also important to note that we are going to try to bring the Department's Domestic Assistance Food Programs to rural people more effectively. We've had a food stamp program in this country for over 10 years now. Too often it hasn't served rural people well. One of the reasons has been the purchase requirement. People in the South, especially in the rural areas, generally, were so poor that they couldn't come up with the basic purchase requirement in order to participate in the food stamp program. They were locked out because they were too poor. They were also discriminated against, in effect, by the fact that we had itemized deductions, and an itemized deduction for housing and child care and medical expenses and transportation expenses tended to benefit those people in large urban areas, especially in the Northeast, and to be disadvantageous to rural people.

The new food stamp reform law that the President signed last week eliminates the purchase requirements for food stamps. We expect that about three and a half million new people will come into the food stamp program as a result of that. The overwhelming bulk of them will be from the rural areas and especially the rural areas of the South.

At the same time we're expanding the women, infant and children supplemental feeding program. That's a program that those of you who work in family planning should be familiar with if you're not. It operates out of local health clinics. It provides a special nutrition supplement to low-income women who are at nutritional need during the time that they are pregnant, while they are lactating, and then provides it to their children up to the age of five. The law was passed in 1972, and the last Administration simply refused to administer it. The Consumer Federation was one of the organizations that went to court and sued the Department of Agriculture to make the WIC program be administered. It's now in 300 counties.

I hope that in the next four years it will see a major expansion because I think that it has a magnificent effect. It provides nutrition to women and to children. It provides a way to keep them in the health clinic program so that they are getting prenatal care and post-partum care and family planning services. I think that the WIC program and family planning program need to operate and should operate much more closely. In order to make WIC serve rural people better, we have just published new regulations that will alter our requirements somewhat. In the past, a WIC program had to operate out of a health clinic. Now, if there is no health clinic available, we'll make provisions for the WIC program to operate out of a county welfare office, perhaps out of a family planning clinic, perhaps out of a doctor's clinic, but I hope that we'll see a substantial expansion of WIC in rural areas.

Obviously, one of the areas where we need more work in rural areas is the one that you're most interested in and that, obviously, I have a continuing interest in, and that's family planning services. Ten years ago last month, the President's National Advisory Commission on Rural Poverty issued its report entitled *The People Left Behind*. It described the problem of rural poverty as "so widespread and so acute as to be a national disgrace." Among its 12 recommendations to deal with this problem, the Commission called for:

> Development and expansion of family planning programs for the rural poor. Low-income families are burdened with numerous children to feed, clothe and house. They are prepared psychologically to accept family planning. As a matter of principle, they are entitled to facilities and services to help them plan the number and spacing of their children.

When I joined the staff of the Institute (then known as the Center for Family Planning Program Development) in 1969, the Commission's report, along with similar recommendations from White House Conferences on Civil Rights and Health and other leading groups, was a significant part of the broad support that was mobilized and led to the passage in 1970 of the Family Planning Services and Population Research Act. This landmark legislation, of course, launched the national family planning program and has been its principal source of support ever since.

Back in 1969 we worked on the premise that the family planning problems of rural America could only be solved through a national priority program and that a national program, if it were designed properly and evaluated vigilantly, could speed the extension of modern family planning services to the rural poor. We were aware of the many public programs that never seemed to reach into rural America. But we were convinced that this need not be the case for family planning, both because the service did not require a very complex delivery system and, more importantly, because the poor women of rural America had shown conclusively their interest in family planning in order to improve their lives and the lives of their families.

In a sense, then, this Conference gives me a personal opportunity to look back and see how well those premises have stood up. And it gives me an opportunity to relate your concerns with the mission of the Department of Agriculture which is to improve the quality of life of rural Americans, to do everything we can to insure that they are no longer the people left behind.

I am pleased to learn from the material presented here that the family planning program in rural America has come a long way. Your data show that organized clinic programs are available in nearly four out of five nonmetropolitan counties which surely must represent a broader diffusion of services than in any other national priority health program. Since 1968, the total number of patients served in nonmetropolitan family planning programs has increased from 144,000 to nearly one million in 1975, an increase of nearly seven-fold. In fact, the rate of growth in nonmetropolitan counties has been greater than in metropolitan areas.

These are significant accomplishments of which all of you who provide services in rural America should be proud. A good deal of credit also belongs to the federal government for two reasons: (1) without its priority support there would have been no national family planning program in either our cities or rural counties; and (2) the federal program has, from its inception in DHEW's first Five-Year Plan for Family Planning Services, emphasized the rural service deficit and allocated its resources so as to reduce that deficit. That has not been typical of many federal health or social service programs.

If we have indeed come a long way in the last decade, the other side of the coin is that we still have a long way to go. Between 1.5 and 1.8 million rural low- and marginal-income women at risk of unwanted pregnancy could not obtain family planning services in 1975 either from clinics or private physicians. The proportion of rural sexually active teenagers who were unable to get services was even greater. Very few hospitals in nonmetropolitan counties provide family planning services, and there are no organized programs at all in 541 rural counties.

These remaining problems can be solved, just as the problems of 10 years ago could be, if family planning workers and organizations concern their efforts—and if the federal government can marshall the national will and the national resources needed.

One area that I think is worth exploring is the use of people who are already working with rural people in the delivery of family planning services. Agents of the Department's Agricultural Extension Service have worked with rural and small town families for years and years in this country. They provide an enormous range of diverse services and deal with diverse problems and questions. For a long time extension agents dealt primarily with production problems and with homemakers' services, but more recently, by act of Congress, the Extension Service has gotten into nutrition education programs. Extension agents train aides—nonprofessional aides—to work in providing nutrition education to low-income people in rural areas, and, in some cases these days, in urban areas. The program is called the Expanded Food and Nutrition Education Program, and the people are known as EFNEP aides. (God help us if we were to be without initials in the federal government.) Obviously, when EFNEP aides go and talk to families, they talk about a whole range of issues, in addition to nutrition, and studies show that one of the things that they talk about is family planning services.

A survey of agricultural extension services conducted in 1975 discovered that, at the state level, family planning activities focus on support functions for county agents and aides, emphasizing such things as training sessions and, most frequently, provision of family planning materials. At the county level, many extension agents and aides make family planning referrals to agencies and physicians. But only two of the 37 responding state agencies had a formal policy supporting the provision of family planning information, education or referral. Since 28 other state agencies, however, noted the need for initiation or expansion of family planning services, it seems to me that it would be useful to find out how many have done so, and, if not, what the main obstacles are. This should be something that could be helped by increased federal support and action.

I think that there's a natural tie between you who deal with family planning services in rural areas and the extension agents and the EFNEP aides. I hope that you will work in your localities to extend that relationship. I hope that you will deal with the county aides and the state extension offices to try to extend that program, and I think that we should work with the federal extension organization to try to provide those information, education, and referral services wherever we can.

It's also very important that rural hospitals, the principal institutions in the rural health delivery system, broaden their family planning programs. Right now, these hospitals don't seem to see family planning services as part of their responsibility, and they provide services to only four percent of all nonmetropolitan family planning patients. The drive for these hospitals to broaden their family planning services is going to have to come from people like you—informed professionals—and it's going to have to come from rural women and people who work with rural Americans.

Obviously, the most glaring deficient area of service for rural women and, obviously, the most difficult one to deal with, is abortion. There are no legal abortion services in over 90 percent of nonmetropolitan counties. When the Supreme Court legalized abortion it did so for all women, not just for urban women. For most rural women that Supreme Court decision is just a paper decision. It has had very little meaning.

Let me make myself clear. Obviously, I do not speak for the President of the U.S. I don't speak for his Administration on the subject of abortion, but my history in this field is a long and active one, and I do believe the Supreme Court's decision was the right one.

Second, I obviously do not advocate abortion as a method of family planning. I'm sure that no one seeks abortion without a lot of long and difficult thought. I hope, as I am sure that all of you do, that someday family planning services will be so available, the methods will be so efficient and so convenient, that no one will have to rely on abortion. That day is not here and now, but federal government funding for abortion services is at an end for this year and probably for some years to come. The provision of abortion for low-income women in need is threatened. I don't have a solution to that problem. I wish I did. I can only urge that you, AGI, you who are involved in rural family planning services, the people that you work with, the people who provide funding to you—the non-federal funding—begin an even more active search for other sources of funding and for other sources for abortion services. In the short term, that is just about the only choice that we have. In the meantime, I think that a federal government that is *not* going to provide abortion to low-income women takes on the responsibility to provide compensating services. I hope that we'll expand family planning services even more. I hope that we'll expand contraceptive research and sex education.

In addition, it's obvious that we have to provide better health care to those children who are born of low-income women. I think the WIC program is one of those programs that must expand to provide services to children born of low-income women. I think the WIC program is one of the best examples of one that must be expanded. We're a country that says that we are pro-life and we're pro-children. Whether or not we provide for the adequate care of those children through programs such as WIC—there's a pretty good case where we have the opportunity to put our money where we say our hearts are.

Clearly, there's a need nationally for action as well as locally to provide family planning services to rural women. I'm glad to be here speaking to you carrying the title of Assistant Secretary of the Department of Agriculture. But long before I was in government, I was an advocate for consumers, and long before that I was an advocate for family planning services. As the Department of Agriculture begins to search for its renewed social purpose, I can assure you that I'm going to be there trying to see that the women you serve are not forgotten.

Panel Discussion

Rural Family Planning Programs: The Administrative Perspective

Moderator: Harvey Dershin
Executive Director
Illinois Family Planning Council

Participants: Sara Reed DePersio, M.D.
Director
Maternity and Family Planning Division,
Oklahoma State Health Department

Lewis W. Mondy, Ph.D.
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Texas State Welfare Department

Willie D. Hamilton
Executive Director
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Edward D. Martin, M.D.
Director
Bureau of Community Health Services
Public Health Service, Department of Health,
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(Presented by Vivian O. Lee, Regional Program Consultant
for Family Planning, DHEW, Region X)

Jack Leath
Director
Division of Family Planning Services
Tennessee Department of Public Health

Reactor: Harvey Dershin
Executive Director
Illinois Family Planning Council

State Health Department

SARA REED DePERSIO, M.D.

Director
Maternity and Family Planning Division
Oklahoma

The Oklahoma State Department of Health became officially involved in family planning in 1967 when the state legislature authorized the State Department of Health to establish and operate family planning programs. The first federal funding for the program was through the Office of Economic Opportunity. In Fiscal Year 1971, the state legislature appropriated $200,000 to the State Department of Health for family planning services. This appropriation amounted to $2.21 per woman in need of family planning which was the fifth highest appropriation by a state legislature in the nation according to reports from The Alan Guttmacher Institute. This year our state appropriation was $425,000. The monies plus the Title X and Title V funds total some 3.8 million dollars for family planning in Oklahoma this year. These figures do not include the contribution of staff, consumable supplies, and facilities which are supplied by local health departments which are not accurately quantified in dollar amounts at this time. At this time, there are no Title XX or Title XIX funds in this program. We have the authority and precedent to charge patient fees but for the present have not elected to do so.

With the exception of Tulsa County, our state agency administers all of the Title V and Title X funds coming into the state which allows for full coordination of these two major federal funding sources. The Maternity and Family Planning Division is integrated into the MCH Services. We maintain a family planning central office staff of myself as program medical director, a social work consultant, nutritionist, nurse consultant, training specialist and two statisticians. In addition, we do rely on other administrative and consultant support from within MCH Services as well as other program areas of the agency. Our family planning services are provided through 60 county health departments, two free standing clinics, the two Planned Parenthood Associations in the state in Tulsa and Oklahoma City, a Neighborhood Health Center, Migrant Health Project, Community Action Agencies in five counties without health departments, the University Hospital, Women's Clinic and Indian Tribal groups. In Oklahoma, county health departments may contract with each other and staff can cross county lines or work in regional efforts.

Of the 153,275 women in need of family planning services at 200 percent of poverty level, slightly over 45 percent received services from publicly supported family planning programs in 1976. This figure includes the approximately 5,600 women who were served at Indian Health Service Clinic sites (there are no Indian Reservations in Oklahoma) and 6,800 by Title XIX in the office of private physicians as well as those served by the Title X and Title V program. In our program, a greater percent of need has been met in the nonmetropolitan counties as compared to metropolitan counties.

In describing how a state agency might serve in extending rural family planning services, I would like to outline what we have been able to do. Initially, we were funded as a state grant to implement services in about one-half of the state's 77 counties. Our approach was to develop a system of administrative technical support at the state level for these initial programs which could be expanded to include other areas as funds became available. These state level administrative and technical capabilities have allowed local programs to be implemented without having to duplicate these major expenses in each area. One year ago, we underwent a consolidation of the 15 CAP family planning grants with the State Health Department. One positive outcome of this was the elimination of duplicative administrative costs which the CAP previously had to maintain. Our centralized support services for patient reporting, fiscal, personnel, and purchasing relieves the local program of much administrative hassle. Administrative workloads created for small local agencies by new programs are often a detriment to getting services implemented.

By maintaining a state family planning core staff as previously mentioned, we were able to provide technical assistance to local programs in medical areas, nursing, nutrition, social work, and outreach. These staff members not only are responsible for (1) program development, (2) patient care standards, (3) quality assessment, (4) program evaluation, but also we all provide direct services when the need arises. As a program of a state agency, we are able to utilize the professional staff from other areas not funded by family planning. For example, we have in the MCH program a network of Child and Family Guidance Center services which employ almost 200 professional personnel in the areas of psychology, speech and hearing, social work, child development, and psychiatry. We are able to utilize this resource for counseling to family planning patients who may have marital or parent-child problems, sexual dysfunction, problem pregnancy, or other difficulties.

More recently, we are finding the WIC Program to be valuable, not only in terms of a resource to family planning patients who are at nutritional risk, but also as an outreach program for finding those women who are in need of family planning services.

One component which we are able to support as part of a statewide grant is our patient reporting system and the statistical staff capabilities which allow us to obtain data for each county program and provide interpretations of this information to the state and local staff for program evaluation and planning purposes.

Our particular program structure has allowed us considerable flexibility to shift available financial resources as local programs change or needs dictate. As some local programs demonstrate a greater need and productivity, we have been able to respond fairly quickly to meeting this need by shifting funds away from the unproductive program's activities. We are not locked into never-ending funding commitments. We review each program at least annually or at any time we feel indicated and make funding adjustments. The most effective procedure is a review of each position as it becomes vacant and making new determinations as to whether it should be refilled, deleted, or funds channeled into more productive measures. Our centralized budgeting process allows us maximum utilization of the available dollars by immediately reclaiming and reallocating lapsed funds which might occur in any local program.

Our success in getting increased state funds is due in large part to the concerted effort which can be made by all local programs on their state legislators for one common appropriation bill. In funding local programs, we are able to utilize some of the local health department county appropriations for family planning. We are, however, finding the local dollar harder and harder to obtain as local tax bases do not keep up with the rate of inflation. We continue to stress that the available family planning project money is to *assist* local programs in carrying out family planning services and is not intended to provide them with the full costs of the services. After several years and many attempts, we are still not able to secure third-party reimbursement from either Title XX or XIX. Currently a lopsided Title XIX proposal is being discussed in which the only services which would be covered are the physician exam and the cervical cytology laboratory test.

Nearly all of the family planning services provided through the local health departments are provided through the specialized clinic arrangements. We feel this is important to insure the quality of care and to serve the patients efficiently. We do feel that there should be a clearly identified family planning component in order to maintain high visibility for the continued success and in order to serve in an advocacy role for the program. Utilizing the local health departments for the small rural areas is beneficial from the standpoint of not having to duplicate the physical facilities and certain basic personnel requirements. Also, it provides a full-time operational facility to which patients can relate. Such arrangements would not be as economically feasible otherwise for many of the rural programs. In those areas in which an organization (either a local health department, Planned Parenthood, CAP or other primary health care facility) is not available to sponsor family planning services, we have established free-standing clinics sponsored by the community. We are able to do this legally as an extension of the state agency. Although we find these programs are more expensive, we are able to lessen the overhead costs because of the centralized administrative support services and certain regional staff we can provide for these situations.

We have been successful in working out arrangements for various referral needs of all programs throughout the state. These referrals for services which are usually not otherwise available, particularly in the rural areas include: (1) dysplasia clinics, with colposcopy, biopsy and cryosurgery, (2) sterilizations, (3) infertility, (4) complications, (5) postgraduate training—for both rural and urban physicians and training, in general, for all other staff members.

We feel that family planning programs have become such an integral part of the local health departments that if by some strange set of circumstances family planning federal funds should disappear, family planning services would continue—certainly, however, not meeting the current demands for services or with the present quality of care as it does now.

Surprisingly, however, there are some drawbacks to working through a state agency. Changes in administrative policy must be considered from the standpoint of the whole agency and can be very slow. As an example, establishment of a family planning costing system requires a change in the department's total fiscal system and involves all department program areas. While state agencies are able to offer more job security, low state salaries and strict personnel qualifications hamper recruitment of staff. State agencies are more restricted in supporting or taking leadership roles in certain controversial family planning issues.

In the small communities where there may be only one doctor available to provide services, one is, of course, more dependent upon him for the success of the program. One must be more flexible in considering his desires. We feel, for ongoing community support, engaging the local physicians whenever possible is preferable to bringing in an outside clinician. We do, however, employ third year ob/gyn residents, Indian Health Service doctors, and, in a few cases, other physicians who travel to cover several counties.

Costs per patient are somewhat higher in the rural areas because of the fixed costs/volume relationship and should be considered when comparing program costs. Our highest costs are in two counties where CAP programs are currently using the physician referral mechanism.

Outreach and follow-up services are more time consuming than where the women in need are concentrated in smaller geographic areas. We are finding a great need for evaluation of rural outreach services and we are searching for standards to use in evaluating the outreach activities which we feel are necessary.

Nineteen of the 77 counties in Oklahoma have been designated as critical manpower shortage areas. Only two of these critical shortage counties together containing 561 women in need of family planning services presently do not have organized family planning programs.

In addition to manpower shortages, 42 of the 77 counties in Oklahoma are classified as underserved as a result of the scarcity of organized health care delivery systems. Even so, only two of these 42 underserved counties do not have the organized family planning programs. In 1976, 22,257 women received family planning services in these medically underserved areas in Oklahoma. It is true, however, that for many of these women the services of the family planning clinics are the only medical services they may have received.

The physician/population ratio for the state as a whole is 1:759. Eight counties in Oklahoma have a physician/population ratio greater than 1:3,000.

In addition to the problems of physician manpower, other types of health manpower are difficult to recruit for rural areas. Public health salaries for nurses are generally not competitive with local hospitals and private offices.

The most difficult positions to fill in rural areas, aside from physicians, however, are those for registered dieticians and master's level social workers who would be asked to provide services on a regional basis. Thirty-four counties do not even have a registered dietician living within their boundaries. When these types of staff can be found there is a definite advantage to share them and their cost with other counties and with other public health programs when they are not needed full-time in family planning clinics. An example of this would be the nutritionists who are shared by family planning, WIC, maternity and pediatric programs.

Shortly after the first Title X funds were made available in 1971, the need for additional manpower of a new type—the nurse practitioner—was recognized. The agency acquired the cooperation of the Department of Gynecology and Obstetrics, Oklahoma University College of Medicine in training nurses to be primary care providers proficient in the area of family planning. In the past six years, over 50 ob/gyn nurse practitioners have been trained in this program. The state agency was able to hand select aspiring and talented public health nurses from all over the state who would attend classes and clinics for six weeks with medical students and then return to their home county and surrounding areas to care for family planning patients. Physicians have been willing to serve as back-up and provide standing orders for these nurses and have agreed to do so prior to that nurse's training. Nurse practitioners have been well received by our patients, and, in general, by the medical community. Seven of the total 21 nurse practitioners who work in family planning work on a regional basis across county lines to provide services in 30 counties all of which are considered to be rural areas. For these nurse practitioners who cover from four to seven counties each, there is a great deal of travel which is, of course, expensive in time, however, for the total group of 21 they presently average 2,260 encounters per full-time equivalent on an annual basis. We feel this ability to select qualified nurses who are already permanent residents of rural areas for training at a university within the state has been a highlight of our program.

State Welfare Department

LEWIS W. MONDY, Ph.D.

Program Manager
Family Planning and Family Services Division,
Texas

I'm here this morning to describe to you something of our Title XIX and Title XX family planning programs which we consider to operate in a cooperative complementary relationship to one another. Then I want to give you some perspectives of my own upon the administration of family planning programs through a welfare mechanism.

This Welfare Department that I represent appears to have one of the larger sets of family planning programs in the country, and that's ironic because for years the Texas Welfare Department largely ignored family planning altogether, even though the first OEO family planning grant was made to a Texas agency in 1964, and then Medicaid came along the next year and made family planning an optional benefit. Nevertheless, the Texas Welfare Department ignored the possibility of including family planning in its Medicaid program. It wasn't until 1973 that we began to offer family planning services at all. Prior to that, there was a ludicrous situation where a few doctors "in the know" would prescribe oral contraceptives and even insert IUD's and bill for these services "for the regulation of menstruation." That's obviously ridiculous on the fact of it, particularly when you think about inserting an IUD for that purpose. Nevertheless, a few doctors "in the know" were able to obtain payment from the Medicaid program by billing for services "for the regulation of menstruation." Fortunately, Congress amended the Social Security Act in 1972 and forced our state and some other states to get going with family planning. You'll recall that those amendments of 1972 mandated welfare departments to offer family planning services and to provide them promptly upon request to AFDC recipients. There was a penalty provision of one percent of the state's AFDC funds for failure to comply, but there was also the "carrot" of a 10 percent local match required, as opposed to whatever the regular Medicaid match might be for that state. Also, the Title IV-A match was only 10 percent for family planning. The 90/10 percent matching ratio is quite an incentive for states to get going with family planning programs, and ours did.

We were facilitated by having a centralized administrative mechanism. It appears to me that where state welfare mechanisms are highly decentralized, as for example in Minnesota, where there are 87 different county welfare departments, that presents some terrible problems in implementing Title XIX and Title XX family planning programs. If your state has that situation, it appears to me that you are in trouble. If you have a highly centralized mechanism as ours is, then it's relatively easy to go ahead with effective programs that are consistent statewide.

I'd like to describe our two programs in a little more detail beginning with Medicaid, the Title XIX program. We restrict eligibility for our Medicaid program to recipients of cash assistance. We have no broad category of medically needy persons, and that is a serious deficiency with our Medicaid program and something we are in the process of addressing. Thus, we have a relatively limited category of persons eligible under Medicaid in Texas. We do, however, include all of the possible providers of family planning in the Medicaid program, meaning physicians and hospitals, as well as a broad variety of independent agencies. We certified the agencies according to several criteria: (1) there must be a record of established services, and we judge this by the agency presenting evidence of established clinic times, established clinic sites, and an established system of medical records. If these exist we say that there is a record of established services. It's not defined in terms of so many weeks or months or years of being in business, but these other things determine a record of established services; (2) there must be a designated medical director. This is critical for us, because we have no licensing of agencies in Texas. Rather, we're relying upon the professional responsibility of these medical directors to assure that there will be quality services provided. We have not been burned by relying upon the medical directors, but this is a critical component of certifying agencies for participation in the Medicaid program; (3) we require that each physician providing services through an agency sign an agreement that he will not bill on his own Medicaid number, which would be a possibility, in order to preclude the possibility of double billing.

When these criteria are met, then we award what we call a Title XIX Family Planning Agency Vendor Number, a special vendor number, which is the "ticket" for participation in the Title XX program. There are no other criteria for participation in the Title XX program other than having passed the tests for Title XIX. Our Title XIX program for this state fiscal year is funded at five million dollars with all of the matching funds having been appropriated by the legislature. That's not true with Title XX where numbers of agencies are contributing local match, but, at least for Title XIX, we've been able to get the state to match completely. All the fiscal aspects are handled by an insurance company—it was formerly Blue Cross, but now we're dealing with another company—and that's proved to simplify the administration of Title XIX a great deal.

Let me inform you of a concession we've had to make to private medicine. In the Title XIX program, unlike the Title XX program, agencies are specifically excluded from billing for surgery. Rather, they must effect referral relationships with private doctors and hospitals for family planning surgery. This really hasn't proven to be an obstacle, but it's a little bit annoying for numbers of agencies that have vasectomy clinics or female sterilization clinics or pregnancy termination clinics. Nevertheless, agencies have managed to effect referral relationships, and no Medicaid-eligible woman is denied surgery because she's unable to get it through a family planning agency. This was the single concession to private medicine—that the surgery would always go to a private physician or hospital.

Another note about surgery. We've determined that we are able to continue to include menstrual aspiration as a surgical benefit where the procedure is performed prior to a reliable diagnosis of pregnancy. I don't consider this as having found a loophole in the abortion regulations, but, rather, I consider this just a straightforward recognition that one does not have an abortion without a diagnosed pregnancy, and, consequently, we're proceeding to provide menstrual aspiration benefits and drawing down 90 percent federal financial participation. This is clearly not a solution for a great many of our potentially pregnant welfare recipients, but, nevertheless, it provides a certain service that otherwise might not be available.

I also want to tell you about a unique addition to our Medicaid family planning program—something that we sort of stumbled onto—and I don't believe that anyone else has stumbled onto this. We have determined by inquiry to HEW that we are able to define genetic services as family planning, and the importance of this is that we are able to draw down 90 percent federal financial participation for a wide variety of genetic diagnostic and counseling services. As a matter of fact, we've identified over 400 services that appear to be eligible for 90 percent federal financial participation as being related to genetics. These go all the way up to an intensified CAT scan for which we're preparing to reimburse $550. We're just getting into family planning genetic services at the present time. We think that we're going to have something that we would like to invite all of you to come and see. We're quite excited about this, because evidently this question was never broached to HEW before, as to whether one could in fact call genetic services family planning, draw down 90 percent federal money, and extend services that appear to be rarely, if ever, offered to poor citizens. I'm not prepared to go into any detail about it, but I'd be pleased to send you copies of correspondence we've had with HEW and a description of the benefits we plan to include in this program.

That pretty well wraps up our Title XIX program. Our Title XX program then builds upon it. Our Title XX program chiefly serves persons defined as "income-eligible," and in Texas a benchmark dollar figure is $8,375 for a family of four which is 53 percent of our state's median income. This program is considerably larger than the Title XIX program, because, as I've said, we don't include a category of medically-needy in the Medicaid program. One interesting thing about our Title XX program is that it is limited altogether to agencies. We are excluding private physicians from participation in the Title XX program. That has not brought down the wrath of the Texas Medical Association upon our heads, and it's working very successfully. We made that decision on practical grounds. I indicated to you that the Title XIX program is fiscally managed by an insurance company. However, we are handling the Title XX program altogether in-house, and, frankly, we just couldn't deal with the thousands of doctors who might otherwise be participating if we opened it up to individual private physicians. We have 75 contracts with agencies over the state (and several of those in turn have subcontracts with other agencies) so that maybe as many as 90 different agencies are participating in the Title XX program. I've indicated to you that an agency becomes eligible for a Title XX contract upon receipt of the special Title XIX Family Planning Agency Vendor Number, and there are really no other criteria. Once an agency has been approved for Title XIX, then it is eligible for Title XX. Our funding for this current state fiscal year is 14.5 million dollars for contract services. That's not nearly enough, and I'm sure we could use another seven or eight million dollars very well in the program. Of that 14.5 million dollars, about seven million of it is matched by the state with the rest being matched locally.

The benefits are rather broad, including treatment of surgical and IUD complications and treatment of infections. We're getting the menstrual aspiration benefit added to the Title XX program. We have a standard contract statewide which certainly facilitates administration. In the absence of a standard contract—if every contract were unique—we would have considerable difficulty in administering this program.

We determined our reimbursement fees by looking at average Medicaid reimbursements for private physicians and taking 85 percent of those average Medicaid reimbursements. This was a critical step because, in fact, this created reimbursement fees above costs for agencies. Agencies from the beginning were able to accumulate reimbursements over and above their costs. This is acceptable to HEW. You certainly don't have to build reimbursements upon actual costs—you can build them upon some reasonable fee basis, which is what we did, and this provides some money, then, for agencies to expand their services. Furthermore, it provides an incentive for holding costs down, because, obviously, by holding costs down, an agency is able to accumulate more reimbursements. Furthermore, we're saying that these reimbursements can be used for anything related to family planning, including the purchase or construction of facilities; we're very liberal in that respect.

We have no restriction upon any agency expanding its services geographically, and in fact, numbers of agencies are doing so at this time. In the beginning, we were sufficiently endowed with funds so that we could accept billings of any amount from any agency. The more an agency billed, the more it was paid. However, the services grew so rapidly and the funding did not keep pace, to the point where it became necessary to impose billing limits upon every agency. This was unfortunate, but it's now a fact of life with us, since the alternative would be to outstrip the resources. However, with the billing limit concept we're not saying that an agency has to provide so many of each of the different services; rather, the mix of services is left up to each agency. It's simply that the agency must remain within its particular billing limit for the year.

I'd like to re-emphasize a point I made about establishing reimbursement fees at a level which not only covers costs but also yields some remainder. I feel that this has been a key element in our program, and it is essential if you hope to use a reimbursement mechanism to extend services rather than remain in place. With regard to the Medicaid program, if your state does not include a category of medically-needy, you ought to be working on this. We certainly are in Texas, because we see this as the next source of considerable funds. You can certainly extend services by the addition of a genetics program, and I'd like to mention a fringe benefit of this. This has gotten us into a cooperative relationship with an entirely different set of persons, particularly persons in the mental health field who have begun to provide some significant support for family planning. We had never gotten support from mental health before. Let me mention the possibility of training under both Title XIX and XX. You can do a great deal by way of extending services through training programs subsidized with these sources of funds, and funding is unlimited for training both under Title XIX and Title XX. We've learned that curriculum, however, cannot be developed with training funds. You've got to have something to train, in hand, to begin with. Training under Title XIX is at 90 percent federal financial participation, whereas under Title XX it is at 75 percent. Therefore, if you can fund your training under Title XIX, it's worth 15 percent to you.

I'd like to make two other brief comments in concluding. One is that if you are in a position to have any influence upon the establishment of a family planning program within your state welfare agency, I urge you to be involved in the selection of the person who administrates that program. Get one of your own in. I can tell you "from the inside" that if I had not been there with some family planning background, a hundred decisions might have been made differently. For example, the decision to reimburse for services of nurse practitioners under Title XX and to reimburse for their services at the same level as reimbursements for physicians' services—it's those kinds of things that can go against you if you don't have somebody in charge who's with you and understands the situation.

The last point is really a corollary of the first, which is that in dealing with any state government agency you're going to have to get political. There's just no question about it—you're going to have to organize and get political. And you should not be afraid of doing this—this is what our system is all about. It's simply necessary to deal with legislators and with the governor, as well as with welfare administrators, and I can tell you, as a state agency person, that I feel very good in knowing that I'm backed by a group that has some political organization to it.

Statewide Voluntary Agency

WILLIE D. HAMILTON

Executive Director
Arkansas Family Planning Council, Inc.

We first started trying to expand family planning in 1971 to be of some significant value in Arkansas. Right off, we had to get into politics. It sounds like we are a state agency: Arkansas Family Planning Council, but it happens that we are private, non-profit with a board of 27 people from all over the state.

In the beginning, in 1971, the state was reaching about five percent of the need in family planning programs, and everyone felt that was bad. The State Health Department felt they would get it going after a while. It happened that the Governor at that time felt that, "You've been working at it a good while and you still haven't gotten it going, so let's try something else for a while, along with what you're doing." So, as strange as it may seem, we had the support of the Governor who told the state health director at that time that he must be involved in the Arkansas Family Planning Council work, and he must allow them to push him on a bit. So, we received funding to assist health department clinics in the state through the use of community action agency programs. The community action agencies were good at outreach in Arkansas, and it was felt that since they know how to do that, and the health departments in some counties go lacking for patients, that was a bad scene. So, with some pushing by the community action agencies, it was not too long before in some areas the clinic staff members were saying, "You must stop bringing so many patients. We can't take care of all these patients. We just don't have the time." In many instances that was a fact.

As I look around the room here at some of the people from Arkansas I see them smiling about what they went through and some of the fights they had and the efforts they made to get additional clinicians to come in and assist them in clinics, and in cases where there were community action clinics established, they got permission on their own and had their own clinics going. As time passed, however, it was thought that coordination should be done well enough so that where clinics were established by health departments, there should not be duplicate clinics, but expansion of those clinics should be allowed for and planned for and funds made available. So that was the approach that the Arkansas Family Planning Council and the State Health Department and local health departments took.

We were serving about five percent of the clients in need in 1971 in Arkansas; now we are serving about 40 percent of the patients in need. We feel a little bit better, but we're still behind. You see, Arkansas is quite a rural state. We have two million people; you could put Arkansas in Atlanta. As a result of being a small state with many problems, we've come a good way, but we have a long way to go.

When we get to all of the sources of income for family planning programs, we had a long fight. Sarah [DePersio] was talking about not getting any Title XIX or XX money. We were fortunate enough to get Title XIX money for family planning right away, and in Arkansas the state matches this. The Title XIX money is unlimited for family planning as long as clients are coming in and qualifying. We do have a medically needy category in Arkansas. All medical services that they need are paid for by social service through Title XIX. The Title XX program is used for outreach and follow-up for 80 percent of the median income in Arkansas. Now, that money is limited. The state match is provided by the state, and contract for outreach and follow-up is a $200,000 contract—very small. So many people are asking for Title XX dollars, they had quite a time deciding where to put the dollars. So we have a small Title XX contract. It beats nothing, I guess, and we are hoping to get it increased. The other sources—such as the insurance and so forth—naturally we're trying to get insurance dollars and any other kind of dollars that are available. We get a few dollars in gifts, but very few, as you might be aware of the same problem. People think many times, well, you've got those federal dollars, why should I give my dollars?

Some of the objectives in our program right now that I'd like to specifically talk about would be handling the teen pregnancy situation. We have a small grant now to do something in that area, and we have just hired six education specialists who have the basic responsibility to get into schools and churches and wherever else they might go to provide sex education information to teenagers. We consider it, from the statewide office, a very important part of the program at this time, and it's a part of the program that could hurt us if we don't do it right. We see a real need to communicate with the persons who are responsible for education in the public schools in local communities on a local basis. We realize that we have a tremendous problem. I picked up a magazine from the school administrator, *The American Association of School Administrators.* It mentioned *11 Million Teenagers*—the publication done by AGI—and I'd just like to read this and then go from there with some other comments. I read this because it seems to me that the school administrators are beginning to see the real need for sex education in the schools. We have noticed it in Arkansas to the point that many principals and superintendents say, "Come into the schools and say anything you want to about sex education. It's yours." And we have other areas where they say, "No, you can't do that because I'm afraid that I'll lose my job," in so many words. So, we have to deal with that, but the majority of schools in Arkansas at this time are saying, "We need information." We are out there planning to give the information and giving it. We hope that we aren't going to have any tremendous problems with people getting information out of context.

The article from *11 Million Teenagers* says:

> Over one-fifth of all live births in the U.S. this year, more than 600,000 babies in all will be born to teenage parents. Another 400,000 teenage girls will either miscarry or abort their pregnancies. This brings to an astounding one million the number of teenage pregnancies expected this year alone. What does the future hold for the teenage mother? She will probably drop out of school. If she is unmarried and unable to find a steady job that pays enough to support both her and the child, she may feel forced to enter into a marriage she may not otherwise have considered. Even if

she is married, statistics show that brides age 17 and younger are three times more likely to split with their spouses than those who marry in their early twenties. In either case, the prospects for living a happy, fulfilling life are dim. Babies born either out of wedlock or to teenagers forced into marriage by an unintended pregnancy run a greater risk of arriving prematurely or having a low birth weight at delivery. Also the death rate among infants born to teenagers ranges from two to 2.4 times higher than the rate among first babies born to women in their twenties.

What's being done about the problem of pregnancy among adolescents? Not enough, says the report by AGI. What can be done about the epidemic of adolescent pregnancies in the U.S.? Although eight out of 10 Americans favor the teaching of sex education in the schools, according to the report, only six states and the District of Columbia require the teaching of family life or some form of sex education in the schools. Twenty-six states and the District of Columbia have laws on the books affirming the rights of teenagers to obtain contraceptive devices. Still large numbers of hospitals, health agencies, and personal physicians still refuse to provide birth control services to adolescents without parental permission.

Now I know all of you are making really good use of *11 Million Teenagers*. We're sending it out all over the state. It costs quite a bit of money to keep them moving, but we feel it's certainly worthwhile to get them. We send them to school districts; all my board members have them; the education department has them. We are really trying to get it out there so that they certainly are aware and have something to go back with and say, "This says thus and so," and they can deal with it. So, we are grateful to AGI for that.

One of the underlying goals of family planning is that every child should be wanted. This, in turn, can give him or her a better chance to receive all the emotional and financial support he or she deserves—a better chance to be loved. When a child is planned and wanted, the quality of life of both child and parents can be improved. Those children who, by accident of birth, are born to persons who are financially unable to support and care for them, will likely be supported with finances derived through taxing. This can be especially true when teenagers become parents.

Education is one method of helping teenagers understand their own sexuality. Hopefully, this allows them to make informed decisions. Teenage pregnancy is a particularly urgent concern.

Teenagers are sexually active as shown by birth statistics, whether we approve or not. One two-fold approach to providing contraceptive information to teenagers is: First, to provide facts and information about reproduction and contraception to teenagers who are sexually active; second, to answer questions about sex and sexuality in order to relieve apprehensions which lead to poor social adjustment. Sociological studies have not shown that either provision of contraception or sex education have increased promiscuity. Ideally, sex education could and probably should belong in the home. There is ample proof, however, that today this simply is not so for many teenagers. It is safe to assume that most of them (indeed, most people) receive the majority of their information (or misinformation) about sex from sources other than parents. How much of it is factual? Is it misleading? Is it contradictory?

We have the responsibility of providing factual information to teenagers with an underlying message that each person is responsible for his or her actions individually. Honest, nonevasive answers to young people provide credibility which is essential as they formulate their individual attitudes.

I will now share with you a summary from a report describing the approach which was used by a rural group in Arkansas to provide sex education in the local school district. This approach will point out the importance of planning acceptable methods or procedures for providing sex education in the public schools. This is a major area of concern to the family planning administrator. Development of a positive community attitude toward sex education is a priority. In this school district the March of Dimes Parenting Program approach was used. The program was presented in a manner which the community would support at the time. The identifying title for the program was The Russellville Junior Auxiliary Parenting Program.

The Russellville Junior Auxiliary Parenting Program

After the observation of unwanted pregnancy statistics, the Russellville Junior Auxiliary became increasingly concerned about the high percentage of teenage pregnancies in their community. In their community, girls from 13 years of age to 17 years of age had given birth to 118 babies last year. In the state of Arkansas, there were 217 births in the 10-14 age group and 7,952 births in the 15-18 age group. These statistics sparked interest and concern from every Junior Auxiliary member.

The health committee, after much research and study, presented the parenting project to the total membership at a project meeting in June. It was approved unanimously. When the project's committee met with the superintendent to present the project, they found the parenting program had his overwhelming support. He was anxious for his school to be one of the first to have a parenting program in Arkansas. Next, the program received the approval of the Community Health and Safety Committee. Support was gained from key people in the community (ministers, health officials, business persons, counselors, etc.).

The format and program was not a replication of anything that had been previously presented throughout the country; the program was designed to fit the specific needs. It was done in three consecutive weeks. It involved approximately one and a half hours each day for four days of one week at each level of Middle School (grades six and seven), Junior High (grades eight and nine), and Senior High (grades 10, 11 and 12).

Students had a choice of electing to take the program with parental consent. A sheet explaining the program was sent home by each student. The health committee, after much diligent study, presented the following format of subjects to individual speakers who were professional people from the city.

TUESDAY: A Physician and Pediatrician

Subject: Obstetrics and Gynecology—Basic facts of life, venereal disease, how you may become pregnant, pregnancy, growth of fetus, and what you do when you are pregnant. Films for high school were: *Childbirth, Venereal Diseases, and Contraceptive Devices.*

WEDNESDAY: Nutrition Specialist

Subject: Nutrition—Pregnancy related to health of baby and health of teenager. Film: *Inside My Mom.*

Subject: Pediatrics—Health of baby when born, what needs to be done, responsibilities of being a parent.

THURSDAY: Psychologist

Subject: Psychological Aspects—The effects of pregnancy on a teenager, how can she cope with pregnancy, what does this do to her life, do you keep the baby, or, what do you do, and teenage pregnancy child abuse.

FRIDAY: Attorney

Subject: Legal Aspects—What litigation girl can bring against boy, should it be just her responsibility, legal right of father, how can she assure child support, financial support during pregnancy, service available, abortions, option of adoption, do you go to school, how do you pay for school and care for the baby?

According to the age level of the students, the format of the program progressed in depth and was modified and presented at their level of understanding.

Two Junior Auxiliary members attended each session as the program developed. They felt an initial importance to encourage a close reliable association between the participating Junior Auxiliary members and the students. Members introduced themselves and the speakers, and gave some background on the Junior Auxiliary. The fact that the ladies in blue were there each day holding the nucleus of the program together helped give the students a feeling of security in the reality that as an organization the Junior Auxiliary was involved and had instigated the program, set up the program, and carried through with it because of concern for them. Upon completion of original plans, the response was very gratifying. They had laid a solid foundation and planned to continue the program. Additional techniques for educating can now be considered in this school and hopefully sex education can soon become a part of the curriculum.

A proper foundation must be built for educating in the schools while we simultaneously develop the package for continued funding, reporting systems and future program needs.

Federal Agency

EDWARD D. MARTIN, M.D.

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Presented by

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It is a pleasure to address the *National Conference on the Delivery of Family Planning Services in Rural America*. This topic is of great interest to me and to members of my staff. Unquestionably, it is appropriate and timely that we look carefully at family planning needs and resources in nonmetropolitan communities. Increasing attention has been focused on the health status and health care problems of rural America in recent years. National, state, and local political leaders, including President Carter, have frequently talked about the federal government's long-time neglect of rural communities and the need to begin addressing major rural concerns. The need for adequate family planning resources is one of those concerns.

A recent article, which appeared in *Family Planning Perspectives* entitled "Family Planning Needs and Services in Nonmetropolitan Areas," provided valuable information on the demand for and methods of providing family planning services in rural communities and ways in which these services might be improved. Let me share with you some of the statistics related to these services:

- 3.5 million or nearly one-third of the women most in need of subsidized family planning services live in the nation's 2,456 rural counties. Fewer than one million of these women received services from either clinics or private physicians in 1974. Organized clinic services are located in nearly three-quarters of nonmetropolitan counties, but most counties with services have only single-agency programs. These programs are primarily operated by the health department. Only six percent of hospitals in rural counties provide family planning services.
- The National Ambulatory Medical Care Survey (conducted by the Health Resources Administration's National Center for Health Statistics) revealed that three-quarters of all family planning visits were made to ob/gyns. However, only 12 percent of all ob/gyns in office-based practices live in nonmetropolitan counties. Moreover, rural physicians in general are also less likely to encourage discussion of a non-acute service such as family planning.
- One of the early goals of the federal family planning program was to establish a family planning service site within a convenient distance of each woman in need. By 1974, there was such a service location in 91 percent of metropolitan counties, but only 72 percent of nonmetropolitan counties had sites.
- Of the 3.3 million U.S. women who received family planning services during 1974, approximately 0.7 million of the patients were nonmetropolitan residents.[1] During that year, 43 percent of all patients received services from health departments, and 26 percent were served by Planned Parenthood affiliates, while hospitals served 17 percent, and other agencies (PHS-supported neighborhood health centers and other primary care clinics, community action agencies and special purpose family planning programs) served 15 percent of the total caseload.
- The type of organization providing the most extensive coverage of family planning services in any given geographic region varies considerably. For example, county health departments in southern states handled from 61 percent of metropolitan patients to 85 percent of nonmetropolitan patients; in metropolitan areas in the East/North Central states, Planned Parenthood affiliates served about one-half of the patients, while health departments served about the same proportion of the nonmetropolitan caseload. In New England, other agencies were the major providers of care in both metropolitan and nonmetropolitan areas; other agencies also served two-fifths of the nonmetropolitan caseload in the West/North Central states. The family planning services provider organization breakdown also varies considerably in the remaining areas of the country.

In September, 1976, Mr. Califano issued a preliminary report to former Governor Jimmy Carter on the status of the American family in which he said, "Families are the cornerstone of national well-being. There can be no more important task than to strive forcefully and thoughtfully to assure the freedoms and opportunities from which they draw strength." Current policy of the Bureau of Community Health Services (BCHS) is not only consistent with this philosophy that emphasizes the strengthening of the family unit, but has made great strides toward implementing programs which service all family members—including the development of family and child health efforts.

The vehicle for implementation of family and child health efforts (which will include family planning activities) in rural areas will be the Rural Health Initiative (RHI). BCHS began an administrative effort in 1975 called the Rural Health Initiative to develop primary care delivery systems in rural communities having the greatest need. To carry out the effort, the Bureau has worked to integrate resources of the Community Health Centers Program, the Migrant Health Program, the National Health Service Corps, the Health Underserved Rural Areas Program, the Family Planning Program, and the Maternal and Child Health Program. Major RHI goals and objectives that participants of this Conference should be aware of include:

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[1] Of these [3.3 million women], 2.8 million were from families with low or modest incomes.

- Targeting as many RHI resources as possible to approximately 200 rural counties of greatest need (i.e., rural counties meeting at least three of the four rural health need criteria[3]).
- Requiring grantees to place emphasis on effective project management, high provider productivity, and movement toward self-sufficiency for reimbursable services.
- Requiring grantees to identify and make maximum use of existing health care resources (i.e., linkage development) and to develop integrated delivery systems.

Within the past two fiscal years, the RHI has gone from zero funding to a total of about 42 million dollars in direct funds (not counting Title V Maternal and Child Health and Title X Family Planning funds) principally from the Community Health Centers and Medicaid programs. The combined RHI and HURA programs funded 191 project grants in fiscal year 1976 and 363 project grants in fiscal year 1977. These projects will provide services in approximately 1,000 of 2,456 nonmetropolitan counties.

The Bureau will use the potential offered by the RHI and associated primary care projects and clinics to broaden the scope of family planning services currently being provided in rural areas. Beyond relying on the RHI, additional measures will also be taken to increase the availability and effectiveness of family planning services.

Approximately three million of the 6.2 million women from low- and modest-income families who are ages 15 to 44 and at risk of unwanted pregnancies do not have access to family planning programs funded by federal, state, and/or local governments or public agencies. More than a third of these women live in rural areas.

In view of the importance of family size in relation to the family's ability to support additional children, both financially and emotionally, and in view of the frequent trauma of childbirth to young unwed mothers, the Bureau will make every effort to reach these unserved women by 1982. The Bureau's efforts are consistent with President Carter's challenge to federal government agencies to take whatever measures necessary to strengthen the support provided to the American family.

Important additional family planning services will be made available through the following efforts:

- Designation of existing and proposed BCHS projects as access points for the delivery of family planning services.
- Increased emphasis on family planning services in Title V supported maternal and child health activities.
- Increased levels of services to Title X supported family planning projects.

In addition to these efforts, during fiscal year 1978 the Bureau will target an additional 21 million dollars in Title X funds and 14 million dollars in Section 330/Community Health Centers Program funds available to existing Title X, Community Health Center, and Rural Health Initiative grantees as soon as the appropriation is signed into law by the President. The allocation of these funds represents an attempt to intensify efforts to reduce teenage pregnancies and to improve family oriented health care for mothers and children through the extension and improvement of health care services to adolescents, 10 to 20 years of age.

While attempting to develop new family planning initiatives and efforts for rural areas, it is equally important to identify problems that exist in the current system of providing these services. Cited below are several concerns and suggestions on how these concerns might be ameliorated:

- Frequently, state family planning agencies do not actively seek to identify organizations (many of which include Rural Health Initiative and other PHS-supported primary care projects) that are capable of providing quality family planning services as a part of the full range of services offered.
- Since it is a preventive health service, the majority of family planning services are provided as categorical services rather than an integrated part of total primary care. Transmission of patient records and adequate patient follow-up is frequently a problem. Moreover, in rural areas where only one or no family planning access points exist, patients either have to wait for as much as 30 days or more for an appointment or will have to travel considerable distance to communities where the services are more readily available. Whenever possible, family planning services should be provided as a part of integrated primary care services, and efforts should be made to improve ready access in areas where inadequate capability to provide family planning services exists.
- The National Ambulatory Medical Care Survey, conducted by the National Center for Health Statistics, indicated that approximately three-fourths of all family planning visits were made to ob/gyns. However, only 12 percent of all ob/gyns in office-based practice live in the nonmetropolitan counties. It is quite important, therefore, that experienced health professionals including nurse practitioners, physician assistants and counselors be trained and encouraged to provide family planning services.
- Traditionally, family planning policy and programs have emphasized the provision of services to women in need. It is important that policy, programs, and providers of family planning services seek to involve men and adolescent boys as well. Decisions as important as determining whether a woman can or should have children and the teaching of responsibility to adults and adolescents must involve men and adolescent boys as well as women and adolescent girls.

In summary, I hope to leave you with a clearer understanding of the role of the Bureau of Community Health Services in working to make additional resources available to ensure the provision of needed family planning services to residents of rural America. Bureau staff are committed to working with our state family planning and Planned Parenthood colleagues to ensure the most effective use of available resources and the targeting of these resources to areas of greatest need.

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[3] Need Criteria: Medically Underserved Areas, Critical Health Manpower Shortage Areas, High Infant Mortality Areas, and High Migrant Impact and High Impact Areas.

State Health Department

JACK LEATH

Director
Division of Family Planning Services
Tennessee Department of Public Health

In 1964, patients who desired family planning services in Tennessee could choose among two or three health departments across the state or one Planned Parenthood agency for receipt of such services. Attitudes in those few health departments providing contraceptive supplies were still quite conservative, as were the attitudes of the general public. By asking long enough and threatening to go to the county judge for help, some patients finally got their contraceptives, usually from a health department that had on hand samples left by pharmaceutical salesmen. It wasn't until 1965 that one metropolitan area applied for and received a family planning grant. Four years later, in 1969, a grant proposal was written and funded for Memphis-Shelby county and five adjacent counties to provide family planning services through health department clinics.

A computerized record system was developed and instituted in 1970, at which time the Tennessee Department of Public Health was serving approximately 5,000 patients per year with an annual budget of slightly less than one million dollars. Since that time, the program has expanded to a level of 165,000 patients per year and an 8.5 million dollar budget.

Today, our family planning funding consists of state and local appropriations, patient fees, private donations, and federal dollars from four sources: Title V, Title X, Title XIX, and Title XX—eight separate funding sources. The two major sources of funding come from Titles X and XX which supply about 3.4 million dollars and 2.6 million dollars respectively. Approximately one million dollars come from Title XIX, and another $822,000 from state appropriations.

We now have 253 family planning clinic sites, more than half of which are in rural or nonmetropolitan areas. We don't feel that it is necessary to make distinctions between rural and non-rural patients in our program in terms of services. People are people, and, regardless of where they may live, they should all have the same access to high quality health care. This is one of our chief program objectives—to provide family planning services to all those who request them with the same standard of care to all.

At the beginning of our program planning for family planning services, we recognized that question number one was, "Where do we want to go?" We set a long-range goal as well as some objectives to be met in the near future. Our second question concerned available resources for carrying out goals and objectives. The resources we examined were funding sources, manpower, facilities, and political support. In 1970, there was very little, if any, of these resources available. We quickly saw that Tennessee's family planning program would have to be implemented on a step-by-step basis, rather than all at once.

The first immediate concern was a lack of medical manpower. We utilized health department physicians, medical school residents, and private physicians to provide the necessary medical care. This still wasn't enough. In 1972 we began training nurse practitioners, more recently referred to as extended role nurses. Tennessee's law is quite indefinite regarding extended role nursing, not fully sanctioning it, but not forbidding it either. Our stance in view of this unclear legal terminology was to promptly start training these professionals. Two recent developments have helped to clarify this situation: (1) an amendment to the Medical Practice Act stating that physicians may authorize nurses or physician assistants to perform any task for which the physician will assume responsibility, and (2) a joint statement by the Tennessee Medical Association and the Tennessee Nurses' Association which recognizes the utilization of extended role nurses.

Our next step was to approach local health departments with the program plans. We were prepared for the usual, and, often justified, objection to a new program that is presented with no provision for additional staff to implement the program. We provided additional personnel for the family planning program to cover several clinics, rather than being assigned to just one clinic which did not have a sufficient caseload to support several full-time personnel. Thus came into being the concept of a team delivery system. Teams consist of a nurse practitioner, supporting nursing staff, and clerical support and are assigned to multi-county or multi-clinic areas.

In staffing our family planning teams, we decided that it would be wise to station one staff member in each local health department on a permanent basis, that is, a person who would not travel with the rest of the team. This person is the nurse aide. Nurse aides perform according to their written job specifications during the time that family planning clinics are actually being held. The remainder of their working hours is spent performing clerical duties and outreach work (patient follow-up and recruitment). These persons perform a wide variety of tasks, and they have been thoroughly trained.

Some local health department staffs began to resist the degree of control at the state level over the functions of nurse aides. Problems arose when we hired staff at higher classifications than others who had worked in the health department for years. In effect, there developed some degree of competition between local health and family planning personnel. After a period of delay in dealing with this problem, we feel that our caseload has increased enough that a reassessment of the staffing situation and its problems is warranted. Presently, we are still using both the team concept and permanently stationed personnel with staffing variations depending on clinic caseloads.

Gaining political support has been an evolving process over the years. In 1971, the Family Planning Act was passed, giving Tennessee one of the most liberal family planning laws in the U.S. The law states that "all medically acceptable contraceptive procedures, supplies, and information shall be readily and practicably available to each and every person desirous of the same regardless of sex, race, age, income, number of children, marital status, citizenship, or motive."

In 1975, an election year for many Tennessee legislators, an amendment was introduced prohibiting family planning services to anyone under 15 years of age without parental consent. A number of legislators pointed out that this was a no-win issue, and they preferred that it not be brought up. The amendment was subsequently hung up in committee and never reached the floor of the House. Today, the original Act still stands. This, of course, enables us to serve many teenagers who might not otherwise receive family planning services. Of the approximate 3,000 new patient admissions per month in Tennessee, close to 50 percent are under 20 years of age. These teenagers are coming from both metropolitan and nonmetropolitan areas.

In the early days of our program, a major problem was spending the money. Because federal grants are funded on a continuation basis, it is vitally important that first year funds be spent in order to prevent cutbacks in subsequent years. We were able to spend the full amount the first year and maintain a spending level that enabled the program to survive.

When our program accelerated we requested funding from Title X. All Title X funds were committed, and since Title X was on a continuing resolution on the federal level, there were no funds available. At this point, we began to look elsewhere for support. Some funding was made available through Medicaid, and a small amount was provided through contracts with Title IV-A. Later, when Title IV-A was replaced by Title XX, a contract was negotiated which actually ensured that it cost more to certify a patient for eligibility than it did to provide services to that patient. Through further negotiation we now have a contract that provides for "patient declaration" and allows for certification by regular clinic personnel, rather than eligibility specialists from the Department of Human Services. Approximately 90 percent of program funds are now spent on direct services, with only 10 percent going for administrative costs.

The difficult step in any program is combining resources in the most effective manner to meet the program's goals and objectives. In Tennessee's family planning program we were dealing with several different sets of rules and regulations, different boards, and many different people. We have been successful in allocating resources and in continuing to secure funding to operate effectively. This success is due largely to our being able to show results and to accurately communicate plans for spending requested funds. Accountability is becoming increasingly important in all government programs, and family planning is no exception.

In addition to accounting for expenditure of funds, we are charged with providing the most effective combination of quality and quantity in service delivery. In doing this, we have found that the ideal in service delivery is reached slowly, by a series of compromises. This strategy has proven to be not only more practical, but safer in terms of gaining legislative support.

Rural Family Planning Programs: The Administrative Perspective

HARVEY DERSHIN

Executive Director
Illinois Family Planning Council

What I'd like to do now is take a few minutes and try to sum up some of the major points that came out of the discussions here this morning, points that I think could be translated into policy or recommendations for public or national policy, and include a few of my own personal opinions as we go along.

My remarks generally categorize into about five areas. We had remarks this morning dealing with finances, administration, politics, program and manpower. In the area of financing, we certainly found out that there were all kinds of variabilities in state appropriations, use of Title XX, use of Title XIX. It was pointed out to us that rural areas often have limited sources to get local funding, and this can be a problem when you have to come up with the match. Also, we find that in rural areas there may be limited health services in general, so what happens is that the family planning resources are stretched over more people who might otherwise be served differently.

We find that, again and again, in areas where you have a small program you have fixed costs and slow growth. Put that together with a low volume program, and what you see is an apparent high unit cost of service. This high cost of service can be ameliorated by integrating these programs, by regionalizing them, by sharing administrative staff. Local health departments and other local programs very often have small budgets and small salary scales. It makes it hard for them to compete with the hospitals, as was pointed out to us. One of the things that's always rankled me personally is that state agencies feel no obligation and are under no obligation under the law to reimburse under Title XIX or Title XX at cost. Some, fortunately, do, but most don't.

Again, because of the volume effect, the notion of physician or staff productivity suffers. When you have a small population, you have a person or physician who may have to travel 30 miles to come to a clinic; his productivity as measured against the larger volume clinic may not look too good.

With regard to the Rural Health Initiatives, 42 million dollars is a big chunk compared to what's in family planning, but when you spread that over a thousand counties and 363 projects, that gives you $42,000 per county or $116,000 per project which is rather meager for comprehensive care of any sort. On the other hand, we found that from the financial point of view, while it may be good to integrate programs, the more programs become comprehensive, the more expensive they get.

With regard to administration we have all kinds of structures, and this perhaps is one of the great strengths of the family planning program. We have state agencies, we have statewide councils and regional councils. On the local level we have been very fortunate; family planning does business with health departments and Planned Parenthoods and community action agencies and you name it. This is essential, and it has been one of the driving forces behind building this program. On the other hand, though, it appears that a regional back-up, regional or statewide back-up core staff, is required. This is necessary for long range planning, for training, for other kinds of services, and whether that has to devolve into regional core staffs depends on the size of the state. The important part of using existing local agencies is, of course, that it helps us keep the costs down; it keeps us out of the bricks and mortar business.

One of the things that most people don't realize is that in many rural areas there are no organized health systems. In Illinois, for instance, I don't think half the counties have local health departments. One of the things that has most surprised me about administration and the delivery of services is that if you look around the counties of this country, you will find that a large majority have rural hospitals—small 30 to 50 bed hospitals; 95 percent of the counties in Illinois have rural hospitals, mostly built with Hill-Burton money. But there aren't many family planning programs in those hospitals—less than six percent according to the statistics.

With regard to politics, it was pointed out to us that local or independent groups are important. It helps to build state appropriations; it helps to build national appropriations; it helps keep the program alive. On the other hand, local groups can often be very difficult to get along with when you want to introduce things like sex education programs. It was suggested, and I think we all agree, that one has to work very closely with the local groups and with the local agencies whether they be professional societies or county boards or whatever.

From the programmatic point of view it was pointed out that specialized identifiable family planning clinics are important. I think at this stage of development of this program, where attempts are being made to merge and submerge family planning into other programs, the point that individual specialized family planning programs are necessary is one that we should all keep in mind.

It was also pointed out to us that in rural areas we have problems of referring patients for follow-up and other complicated services. In some cases, outreach in rural areas may not be cost-effective; in other areas it can be.

One of the things we find, and this is certainly not limited to rural programs, is that when funds are expended on a non-grant or non-contract, expended on a fee-per-service basis, the content of the family planning service can be very variable, and it certainly is not something that we can define ahead of time. We have found though that there have been very innovative interpretations of the law in certain states in order to broaden the content and the concept of service, and I think that is a credit to the lawyers in those states.

From the point of view of manpower, of course, we know that physicians' manpower and professional manpower are short. We also know that local manpower may not have specialized training in family planning, and again and again we've heard about the need for mid-level providers. Certainly, in fact, to use those mid-level providers across multi-county or multi-program regions is to everybody's advantage.

Now, putting that all together, what can we do and what do we need from the national point of view to help build family planning programs? First of all, I think we need better national guidelines or directions on the use of Title XIX and Title XX. I think those guidelines have to address reimbursement for services at least at cost. I think those guidelines have to address the content of what those services should be. I think that we need to look very closely at the Title XX ceiling that we've been living under for the last three or four years. And I think that someone has to look at how Title XIX and Title XX funds are being spent within the agencies that administer them. That applies to Title V, too, because in many cases these funds are not going for family planning, and we know it.

Now the other thing that I would like to address is what we keep hearing about expansions of national funding for the purpose of expanding programs. The fact is that funding levels in family planning have been frozen for years, up until last year, and family planning is the type of program that grows geometrically. We know people come back year after year after year. The program is going to grow geometrically if you do nothing. New funds have been committed, but they have been committed for expansion. But the fact is that they're just barely keeping pace with the increase in patient load and with the increase in expenses and inflation.

I think that it is very clear that we have to encourage the development of multi-county, regional programs in rural areas. It's the only way to spread fixed costs. It's the only way to spread administrative costs, and it allows us to be innovative in piecing together programs—programs that can use health departments and physicians and hospitals and you name it. Family planning providers have been inventive and creative in coming up with ways to deliver these services. In my own opinion, if we can pull these things together in large regional areas, increase the size of those patient populations served in those programs to the level of perhaps a thousand or more, we can have a program that is cost-effective.

I'd like to also say that I think we need to encourage the development of area wide core staffs that are responsible for planning, for administration, perhaps for data processing, training, technical assistance, grantsmanship and politics. Someone has to look at all of these things and pull them together, whether it be a private agency or a state agency, whatever—an independent agency—let's say.

The problems with Rural Health Initiative keep coming back to haunt us time and time again. Family planning, around the county, is structured to deliver services in every county. It is one of the few programs that is. The administrative structures are there. Family planning services are in a large percentage of the counties around the country. Now why in heaven's sake—if one wants to expand the kinds of services delivered—build duplicate services, build parallel services, invent new programs? The structures are there. The councils are there. The health departments are there. The regional cooperatives are there. They can be built on to increase the scope and quantity of service.

On the other hand, I would point out the danger of becoming too comprehensive. This is the pitfall of health services. The reason it's a pitfall is because we never know when enough is enough. We don't know what's too much, we don't know what's too little. There's always more. You can always get a Rolls Royce; you can always go to the moon, and in many cases all we need is a Chevy pickup. Family planning has worked for many years with that Chevy, and it's done a darn good job of it, and I hate to see the program expanded past the point where it can deliver its services reasonably and effectively.

I'd like to point out that, as far as training of mid-level practitioners goes, we need to certainly endorse that. But we must not forget that the people who are trained cannot be forgotten. Three months or six months as a certified nurse practitioner is simply not enough. We need to think about continuing education, bringing those folks together during the year for refreshers, for review, for training to keep those structures going.

There was one comment about one of the states not yet serving teens or not yet having the ability to serve teens. This is something that needs to be clarified. Certainly it is something that the offices of HEW can help us clarify.

As a parting shot, people here today said get political. I agree, get political. People are a little bit reluctant to become political in the post-Watergate era, but the fact is that we're existing in a framework where our lives interdigitate with the government and the people who work for the government. Now, this is not a price system; this is not a free enterprise system; this is not a market system; this is a political system. The only way that you are going to get a program together and the only way that you are going to make it work is to get political. That means local groups, that means state legislators, that means national level Congressmen and whatever. You have to deal with your elected people. That, folks, is democracy.

Discussion

QUESTION #1: I have a question for Dr. Martin. . . . How does the recent BCHS memo affect the current rural health programs, family planning programs, who have quality care, but administrative costs in excess of 20 percent?

VIVIAN LEE: The question is what effect the BCHS cuts in Title X funding, due to administrative costs in excess of 20 percent, will have on the current provision of services to rural areas. Is that about the gist of it?

QUESTION #1: In a sense, but if we have current projects that are delivering quality family planning services and if they have an administrative cost in excess of 20 percent, how will the recent BCHS memo affect these projects?

VIVIAN LEE: Well, quite obviously, it may have a direct effect on those projects; however, to the best of my knowledge, the Bureau is giving the regional office an opportunity right now to respond to the "20 percent" memo and to actually show how any cut in funds would be an undo hardship on an area. Dr. Martin will decide if the regional office justification is sufficient to warrant continuation at the same level or whether the cut would take place.

QUESTION #2: Also for Dr. Martin, on that 20 percent issue. Could Dr. Martin provide us with the means by which the 20 percent was found to be relevant to the field of family planning and the sources of information from which he drew his conclusion that 20 percent had to be used as a penalty for service expansion in family planning? Could you provide us with that information? Most importantly, what is the supporting data that show the issue to be relevant to the field of family planning, indeed to any health care field?

VIVIAN LEE: I think I can answer in part, but I would prefer that Dr. Martin be asked the question himself. We have heard, in Region X at least, that this indicator was derived by review of a number of community health clinics that were felt to be very efficient operations in different areas of the U.S. Their average cost for administration was 20 percent. In Region X it will mean a cut in our regional allocation of approximately six percent.

QUESTION #3: Purely as an item of interest, when the comprehensive health clinics were looked at that were supposed to be very efficient operations, was a uniform audit done on each one of them?

VIVIAN LEE: I can't answer that.

HARVEY DERSHIN: You know, it's unfortunate that Dr. Martin is not here to give direct responses to these questions, and I was wondering whether it would be possible for the archivist or recorder of this seminar to pull these questions together, and, perhaps, we could make a formal appeal for clarification on these things. Does anyone else want to make a few comments on this?

JACK LEATH: There is one more point that should be brought to your attention pertaining to the RHI methodology of funding family planning. There is a conflict in regulations between Title XX and RHI. This conflict occurs in charging patient fees. RHI regulations require that patients whose income is above 200 percent CSA poverty level pay full fee and the patients whose income is between 100 percent and 200 percent of CSA poverty level pay a portion of full fee. The portion payable by the patient is determined by a graduated payment scale. Each state sets the income limitations that are applicable to Title XX. These limitations may exceed or be near 200 percent of poverty level. This may limit or eliminate a graduated payment scale.

In theory, this eliminates the need for Title X funds. If patients would consent to having their income validated and if adequate Title XIX and XX or RHI funds were available, Title X funds would be difficult or impossible to justify. This appears to be the tactic used to reduce or eliminate Title X funding.

HARVEY DERSHIN: Maybe we can clarify this. What we are talking about, for those of you who may not be up to the minute on the local politics, there is a directive from the Bureau of Community Health Services: "Regions which demonstrate that administrative costs on their Bureau Common Reporting Requirements (BCRR) are in excess of 20 percent are to be penalized by the loss of the excess." I think there is some allowance to let them go up to 22 percent. It's pointed out that if the whole program, nationally, demonstrates that administrative costs are in excess of 20 or 22 percent, then the whole program gets penalized and money gets extracted from Title X and inserted into other Bureau programs. This has a couple of problems with it, not the least of which is, as was pointed out, that 20 percent is off-the-wall. In bureaucratese, it's a "definitional norm standard." In case you don't know what that is, I don't know what that is either. Twenty percent is off-the-wall. . . .

QUESTION #4: I was just going to say in talking to a lot of people here apparently the BCHS memo has been released in just one region, but in most of the other regions it officially doesn't exist. I would suggest that we read a copy of that particular memo because most of the people here don't know the terminology.

HARVEY DERSHIN: We have one here; I might point out that the National Family Planning Forum has addressed the issue. The Great Lakes Regional Coalition for Family Planning has also responded in address to the issue, and here is the issue.

This is a memorandum dated July 29th, 1977. It's from the Director of BCHS, and it's to the Regional Health Administrators, Public Health Service:

> The BCHS is firmly committed to the principle of quality and cost effective delivery of ambulatory health care services. A review of the data submitted through the Bureau Common Reporting Requirement (BCRR) system demonstrates that progress is being made toward the control and reduction of excessive administrative costs (administration, housekeeping, maintenance, and indirect costs).

However, there are a significant number of projects where grant awards are apparently being approved with proposed administrative costs (including indirect costs) substantially greater than 20 percent of the project total operating budgets. A number of Regions have asked for more specific guidance in this particular area. The basic Bureau policy is clearly set forth in the "Funding Criteria for Bureau of Community Health Services Programs." The Regions are expected in the grant review and evaluation process to implement this policy by communicating clearly to grantees that grant proposals with projected administrative costs above 20 percent are in definitional noncompliance with the criteria and costs should be negotiated downward. Since there may be fluctuation in costs, projects may range to a level of 22 percent and be considered in accord with this policy if the Regional Health Administrator feels there are extenuating circumstances that are noted in the grant award.

Beginning with the fiscal year 1978 allocation process, a Region's aggregate administrative cost percentage will directly affect the allocation of grant funds to the Region for continuation of existing projects. If a Region's aggregate administrative cost percentage (as computed from the BCRR) for all projects of a particular type (Community Health Centers, including rural health projects, Migrant Health, and Family Planning) exceeds 20 percent, then the Region's targeted allocation (computed from the previous year's base and project performance data) will be reduced by the excess percentage.

If because of excessive administrative costs on a large scale this process results nationally in a net decrease in the allocation of continuation funds to the Region, then the funds taken from the continuation allocation will be used for new starts or special supplemental program activities such as community-wide immunizations, integration with mental health services activity, etc.

In the careful monitoring of project performance, when Regions note continuing excessive administrative costs, or the stated inability of a grantee to operate a project within this expectation, other grantee organizations with the capability of more effectively and efficiently managing a direct service project should be developed to assure that there is no disruption in services to the affected community.

Where this policy may create undue hardship and disrupt grantee operations, the Regions may condition the Notice of Award and request a time-phased plan to achieve the necessary reduction in administrative costs. This time-phased plan should be accomplished within one budget period.

Certain BCHS projects are funded to provide mostly administrative support or are designed as experimental projects. The organizations receiving grant awards for these purposes are exceptions to this policy. These projects should be designated as exceptions by the Region in writing to the Director, BCHS.

Except for those projects so designated, this policy guidance affects all BCHS grantees, including free-standing National Health Service Corps sites, covered by the "Funding Criteria for Bureau of Community Health Services Programs." This policy should be regularly distributed to all those programs and grantee organizations.

QUESTION #5: For those grantees that have administrative costs below 20 percent, what might have happened? . . . Some of the projects in the region have done the BCRR in a different fashion, and it was true that some of the definitions were different, so they have administrative costs to report below 10 percent.

COMMENT FROM AUDIENCE: This seems to have been part of the technical assistance given over the past three years. I have talked with a number of consultants that have been giving the BCRR technical assistance over the past several years. One thing this concept of administrative costs does is it punishes those grantees who have clearly identified their total costs in the application. For example, by mere shift of funds, like Title XX funds that are paying for sterilizations and other family planning services,. . . to administrative costs and then extracting those funds from the Region X application, you automatically reduce your administrative costs. This is my objection to the use of that indicator—it is my understanding that much manipulation of financial data is being done by some of the community health center clinics as they complete their BCRR reports.

QUESTION #6: One question that I have personally is how will the Bureau assure that there will be increased emphasis on family planning in Title V? It was mentioned in Ed Martin's speech that somehow there would be more emphasis on family planning within Title V agencies. Now, within our region, we have one state that puts not one dime of money into family planning and not only that, but the MIC project, which is a huge project, refers all of their post-partum patients to the family planning Title X clinic for their family planning services. So I would like to know how the Bureau can assure there will be more family planning in Title V programs?

FREDERICK JAFFE: These actions by the Bureau are taking place at the very moment the Congress of the U.S. is increasing the Title X appropriation by 23 million dollars or approximately 20 percent. Why is Congress doing that? Because Congress wants the program to expand to serve more people, to prevent more teenage pregnancies, and to do some good. But everything that has been said here shows that what the Bureau is presently talking about is cutting the program back, not expanding it. Dr. Martin's speech did not address the question of what the Bureau is going to do with the extra 23 million dollars next year to expand the program in rural America—or urban America, for that matter. Somehow or other, we have to address our questions not only to Dr. Martin, but we also have the responsibility to inform the Congressmen who voted that additional money that they are not going to get the expansion they thought they put into the budget because the Bureau is planning anything but expansion. The Bureau is cutting back while Congress is putting more money into the program.

VIVIAN LEE: Are you all familiar with the proposed allocation formula to the regions for next year? There are five components. The first three are based on the 1976 base allocation for services: (1) This base will be reduced by the excess administrative costs (above 20 percent); (2) 50 percent of that will be awarded to each regional office based on women in need; and (3) 50 percent will be based on the patients served between January and June, 1977. The fourth component is that all of the teen and underserved county money that was distributed to the regions last year will be distributed in the same way. It is felt that the regions have not had sufficient time to address the teen and underserved county initiative, so those initiatives will continue through Fiscal Year 1978. The fifth component is the new money, the 21 million dollars. There appears to be a conflict between the advance information the regions have been given and Dr. Martin's speech in regards to use of the 21 million dollars. Dr. Martin spoke to putting that money into service for adolescents between the ages of 10 and 20. Incidentally, the BCRR cannot be used to monitor that service because, as you know, five to 12 year olds are lumped into one category, 13 to 17, and then 18 to 21 year olds in a third category on the BCRR. There is no way to monitor 10 to 20 year olds served in programs utilizing the BCRR report. At any rate, the regions have been informed that 21 million dollars are to be allocated in some way based on teen births. That formula is still in process, but it was projected that two-thirds of the funds would be allocated to regions based on teen births or fertility and one-third allocated based on other unmet needs to serve high risk patients.

HARVEY DERSHIN: I'd like to let Bill read the letter [from the Forum to Dr. Martin].

WILLIE HAMILTON: It still is in draft form, so we might change it a bit before it goes out early next week:

> Dear Dr. Martin:
>
> The Board of Directors of the National Family Planning Forum has obtained and reviewed your memo to regional health administrators, PHS Regions one through ten with subject BCHS Regional Memorandum 7725, Administrative Cost for BCHS Programs. We assure you that the Forum is committed to the objectives of high quality and cost effective delivery of ambulatory health care services, and we support your concern for the reduction of program administrative costs.
>
> However, we do not agree that the selection of a norm standard for administrative cost, either 20 percent or some other level, is appropriate at this time for the following reasons. As you will remember, we and a number of other organizations have repeatedly expressed our concerns for the design of the Bureau's Common Reporting Requirements (BCRR) and the complexities and the expenses involved in meeting the requirements. Some of our concerns have been taken into account by the Bureau, others remain. Changes which have in fact been made resulted in a number of revisions in instructions and manuals to eliminate confusions, contradictions and ambiguities. As a result, we feel that the experience of collecting BCRR data for the period January through June 1977 may have been valuable in beginning to work some of the bugs out of the system, but that the data itself represents an inconsistent and weak data base for programs' judgments—especially for resource allocations. In short, we believe that the proposed policy is premature and can only result in arbitrary decisions which are bound to affect some worthy programs capriciously and adversely. We know that this is not the Bureau's intent, since it initially developed a group of program indicators to give a balanced approach, rather than a single criteria. Emphasis on the 20 percent overhead factor alone defeats this balanced approach.
>
> We therefore urge that the policy be reconsidered shortly to avoid confusions and dislocation. At the same time, we urge that the Bureau, in developing standards of effectiveness and efficiency for future resource allocations, take into account not only administrative costs but the other three indicators it has developed.
>
> Sincerely,
> From the Forum

QUESTION #7: I want to make a suggestion. I think one of the keys to your high apparent administrative cost in family planning is contained in yesterday's report. You have very low per patient medical costs compared to other programs, but you have most of the same administrative functions as other programs. By comparison, a comprehensive provider, almost by definition, provides services which cost more. As a result, administrative costs in comprehensive providers tend to be a smaller proportion of total costs than in family planning agencies, and to use the percent of total costs devoted to administration as an indicator in both family planning and comprehensive providers biases the result against the family planning providers. What you need to do is to ask Ed Martin to use administrative cost per patient served as an indicator.

HARVEY DERSHIN: That's an interesting idea. My information, and it is not hard information, of course, is that family planning among all the Bureau projects was either the lowest or among the lowest of all of those projects as far as "administrative costs" go.

Luncheon:

Issues in Service Delivery, Resolved and Unresolved

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I have all these pieces of paper with things scratched out, and my first observation is even when Dr. Martin isn't here he's a hard act to follow. My second observation is that you're the first graduating class of the first 29-hour AGI marathon therapy session, otherwise known as the first rural conference. The treatment you received, and I received it too, I think was a series of some of the most useful, descriptive and relevant presentations I've ever had the privilege to hear. And in fact, I read most of them before I came and they still sounded useful, descriptive and relevant even when I heard them presented. And I hope the outcome is meaningful—as meaningful to you as it is to me. I hope you're taking home with you some new ideas and concepts and I know you're taking home some wonderful memories of new friends and acquaintances. And I hope you're taking home a greater self-awareness in regard to the important movement of which you are an integral part.

On the other hand, none of these wonderful things may have happened to you, and we would like to know in any case what happened to you, so we have not—although this is a perfectly organized conference—even thought of having an evaluation form. So we would really like to hear from you, and we would appreciate it if you would, when you get home, write to Sue or to me or to Fred and tell us what you thought was useful and what you didn't think was useful and how, if we ever did it again, we might change it. If you send us your evaluation, no matter what you say, we will send you a copy of the conference proceedings which we intend to print up and distribute widely—after a little editing!

A number of people here deserve a vote of thanks for their contribution. . . and I'm only going to mention a few: Sue Eisman, Conference Coordinator, Valerie Sterrett, Denora Albury and Kathy Purefoy from our staff who handled all the arrangements, Deborah Lewis, who as you all know, went on to higher places in the federal government and of course couldn't be here, but she had a lot to do with this. And I would be remiss if I didn't mention the Kellogg Foundation; we're very proud of Bob Sparks who has lasted from the beginning to end, and I do know he is very, very nice and he's listened to a lot of you very kindly. Just because he's been nice does not mean you are going to receive a check in the mail. And certainly we want to thank the people who wrote the papers, and the moderators, but most of all to those who sat so patiently and listened. And I must say I've never seen a room full of such shining faces and responsive people, and everyone who spoke mentioned later that it was wonderful to have such responsiveness. So if a necessary attribute is caring, you people obviously care.

I wanted to start with a joke because you're always supposed to start with a joke, and I'm a very bad joke teller, and I always had one for rural meetings because some years ago we had, at another point in our lives, been rural experts when we wrote a number of plans for rural areas under an OEO grant. I had a colleague who also went on to higher places and he was very nice because he would write out this joke for me, and just before I would get up to speak he'd hand it to me. I can't remember it. It was a typical joke that an urban person like me tells to a rural audience like you to make sure that you know that I know that I'm an urban person. So I called him the other day in desperation and found out he was in Bangladesh, but they said that they sent him a cable every week, so I said would you do me a favor: put this on the cable—"URGENT—SEND DRYFOOS RURAL JOKE. STOP." But unfortunately, I didn't get any answer so I guess we'll have to go on from here.

At this Conference we explored a number of myths about nonmetropolitan America; we talked a lot about how rural and urban places are different and how they were alike; we raised a lot of problems and we offered a lot of solutions. Out of the day and a half emerged certain issues which surely must be resolved if women everywhere are to equally share in the right to control their fertility. What did we say about rural people? We said they were living in diverse places all over the country, that they belonged to various ethnic and rural groups, that many of them were just plain folk, and that all of them that we were concerned about—or a good number of them—were indeed poor. We learned that rural women's fertility expectations are not so different; in fact, they have just about converged with those of urban women—but they still have more births. It appears that excess fertility may be more related to income and family size or to poverty than to place of residence. From all this we can surmise that rural women want small families just like everyone else, and they need assistance for preventing unwanted childbearing. That they will use birth control services when made available to them has received solid testimony from the participants at this meeting, whether they were Appalachian, Texas Mexican-Americans, Southern Baptists, French Canadian New Englanders, Colorado rugged individualists. We got the picture that rural women are lining up at the clinic door, even when it takes an hour to get there and four more hours before the doctor's examination. Resistance, yes, but not on the part of the women in need. They are not representative of the power structure in their communities or anyplace else for that matter, and perhaps, unfortunately, they do not control the institutions that make the decisions requiring parental consent for serving teenagers, prohibiting sex education in the schools and abortion services in hospitals, licensing nurse practitioners, preventing construction of new facilities.

Let's review briefly the rural family planning program as it now appears to be functioning in a number of important ways. First, about manpower. It's definitely still a problem in some communities, but when programs have been initiated, physicians or their equivalents apparently have been found. Otherwise, you wouldn't be providing services. Several important solutions to the problems have been mentioned. One of them is paying physicians high fees like $35 an hour. This is probably more than they could have got from Medicaid if they saw the same patients in their offices, because in some states Medicaid pays rural doctors a much lower reimbursement rate than their city counterparts. We've talked a lot about using nurse practitioners and other physician extenders. We've heard a lot about the effect on programs using nurse practitioners—that patients prefer them, that they are available all the time, that they cost less per hour (but we do know they work more hours). For these reasons, the use of nurse practitioners can be quite threatening to the medical profession.

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We referred briefly, and perhaps we should have talked more, about using National Health Service Corps physicians, especially if the family planning funds are going to be used to pay for their program. The impact of young, highly trained, and often quite idealistic physicians on communities with aging, old-fashioned doctors can be enormous. Often the local family planning project director is waiting on the doorstep when the health service doctor arrives in town. Initiating private physician referral programs: we knew about that before, but I think we heard one of the most careful analyses of the assets and liabilities. They do cost more, but in sparsely populated areas they may be the only solution, and as Cathy [McDowell] pointed out, where the medical profession is so resistant to clinics, the only thing to do is use them. In fact, I think that the medical profession didn't come off too well at this meeting, and some of the strongest words came from the doctors we had among us themselves. So it sounds like a case of "physician, heal thyself."

We talked a lot about health departments. A short decade ago I remember very well you couldn't mention family planning in some of our nation's local health departments—in many of them. I never would have expected at that time to hear a director of a county health program say that family planning was the major function of his agency. Yet the availability of federal funds for family planning gave literally hundreds of little health departments the opportunity to deliver direct health services for the first time. As these specialized family planning programs have strengthened, so have the agencies that delivered them. And as Jack Leath said, "in the manner of the tail wagging the dog," these health departments have begun to add other health services onto the family planning model. Other health departments have provided maternal and child health programs for generations, and family planning is offered as a component of MCH. I would hazard a guess that most nonmetropolitan health department clinics, with any potential as sites for family planning, are now being utilized. I don't think there are many clinics out there that don't have family planning that could. And I would also add here that the question of integrating family planning into primary health care is a real red herring because in our experience there is no such thing as comprehensive health care with which to integrate, and I think that's very important to keep in mind. You don't need to keep it in mind, but other people do. When we look to operate new clinics in unserved areas, we'll probably have to look at other types of specialized agencies. In some very conservative communities, and I believe that there still are some, with existing health department family planning programs, we also have to look at other types of agencies to serve what I call the "health department rejects"—namely, unmarried teenagers.

Regarding leadership, and we haven't talked much about that, lots of people are there. Because they're in small towns and isolated places they may have less visibility, especially to us city people, perhaps because they're more accustomed to problem-solving on their own. From the presentations here I have the impression that they find creative solutions, and they have developed innovative approaches which may not appear so much in the public health school curriculum and the American Journal of Public Health, but it seems as though rural people are problem solvers. For example, thinking about distance—we always heard it was such a terrible problem and such a barrier to service—and yet I didn't hear anybody talk about that as though it was something that was insurmountable. Obviously, if people can't get to your clinics, you bring the clinics to the people, either through moving the staff around or arranging for patient transportation. You also should think about us in the city—that traffic can be a terrific problem in cities. If you've ever tried to go somewhere on the New York subways, I think you would know that it's sometimes easier to get over the White Mountains of New Hampshire than it is to get from Brooklyn to New York everyday. I think the mobile units, which we used to hear a lot about, didn't seem to fare very well at this meeting. It seems like everybody's broke down before it got to any patients. That may be an idea whose time has passed—at least in the U.S.

Resources. Yes, they are slightly less available in nonmetropolitan areas. From a recent study—one of the few recent studies we haven't referred to yet—we have determined that the total amount of money spent on family planning in the U.S. in 1976 was about 260 million dollars. Approximately 60 million dollars of that, or 23 percent, was spent in nonmetropolitan areas. So the nonmetro score at half-time is about 25 percent of the patients, 35 percent of the need, 40 percent of the unmet need, and 23 percent of the money. Because health departments are so heavily involved, nonmetropolitan programs apparently get a large share of state appropriations in Title XX. In the early days of Title X, when project grants went directly to agencies, rural multicounty community action agencies were better organized to ask for grants than any other type of rural agencies. While many Planned Parenthood affiliates also received direct grants, very few had rural programs. In recent years, more and more federal funds are channeled through state health departments which give them considerable power over allocation of resources. In some states this has resulted in a redistribution of federal funds away from cities and toward outlying areas which is one of the reasons why I think the percent of the total service load in nonmetropolitan areas has gone from 17 percent to 25 percent in the last eight years, as you heard the other day.

Finally, about costs. The big *preliminary* news that came out of our study was that family planning in nonmetropolitan areas does not necessarily cost more than family planning services in metropolitan areas. We also reported that small programs are more expensive and so are private physician referral programs. Multi-state and multi-county programs may serve more patients, but the cost per patient served appears to be the same as for single-site agencies. At the same time, we pointed out that we didn't think there was any virtue in very large programs; in fact, we cited evidence that an optimum size for nonmetropolitan areas' programs may be around 1,500 patients.

In summary, rural people are not so different from urban people in regard to their fertility expectations and experience. If they are poor—and they are—they have a lot of problems, and excess fertility compounds the problem. The demand for family planning services is becoming more visible every day as small town America and big city America converge in regard to values, mores, and behavior. In some respects, you can thank or blame television for this convergence—depending on whether you think it's desirable or undesirable. But we can wholeheartedly applaud the family planning providers for their part in this piece of social change. There is no question that the development of access to medical family planning services has given many—more than a million in one year—nonmetropolitan women the capacity to control their fertility, and, within the limits of contraceptive effectiveness, the capacity to bear the number of children they want. But providers in metropolitan areas have done the same for at least three million women this year, and they express the same need for additional support and priority that their nonmetropolitan colleagues require. This brings me to a few thoughts about the future. What are the unresolved issues in addition to our problems with the government?

The major issue, of course, is how to serve the unmet need. There are a minimum of one and a half million adolescents and low-income women over 20 who may need subsidized contraceptive care in the next couple of years. A set of issues revolves around programs and policies for the future. A rather detailed program for the future for the delivery of family planning services during the next five years is described in *Planned Births, the Future of the Family and the Quality of American Life*,[1] a publication I hope you'll all read and actively support. With all that's been said about the similarities between urban and rural areas, it would seem that the seven new initiatives outlined would be as essential for residents of one community as another.

The major approaches required to serve the unmet need, in addition to maintaining the current caseload now utilizing family planning clinics, are first of all to develop effective adolescent services, including sex education, counseling, examination, prescription and follow-up. Secondly, an approach which we really have not discussed here and we should think about a great deal, is to identify and assist older women who are still experiencing unwanted pregnancies. We've been so actively involved in teenagers, sometimes I think that a woman over the age of 30 or maybe 25 would feel funny walking into a family planning clinic with all that incense and all those jazzy posters. We think we may be doing the teenagers a great favor, but we may be scaring away older women, and they are very often the ones with high parity unwanted births. Abortion surely is a necessary intervention as long as women are having unwanted conception.

To implement all these programs, a number of policy changes will have to occur. And this can be quite difficult, as you have pointed out, in conservative small towns where positions on controversial issues are speedily transferred and transmitted from person to person. This is one of the hazards of health department dominance. No matter how the staff may feel about a program, it must be approved by an elected Board of Commissioners or a politically-appointed Board of Health, and the policy of parental consent for teenagers is still being enforced under local options, even in states where the statute has been changed. If I lived in a place with a health department as the sole provider and no teenage services, I would think about connecting with another type of agency located elsewhere in the state, like a Planned Parenthood affiliate or community action agency, to see if they were interested in opening a clinic in my town. Just the threat of competition, of course, might be an effective tool for getting the Board to change its policies. In New Hampshire the threat of removal of all Title X funds from the State Health Department, unless they approved services to teenagers, had an enormous effect on such a personage as Governor Meldrin Thompson. An immutable policy of informing parents when teenagers came to clinics was revoked with dispatch, and the funds continued to flow.

There are a number of sound arguments for a more diversified delivery system than now exists in rural America. Several studies have shown that the greater the mix of agencies, the more succcessful the program. And this is probably because some women want to use different sources of care than other women, depending upon their age, their stage and their marital status. In fact, this is one of the characteristics of the family planning delivery system. Now, what about the hospitals? We all sound like broken records, because we've all mentioned it when we say that the nation's hospitals have the potential for providing family planning services in almost all underserved areas, yet the level of their participation is minimal. They must be drawn into the family planning delivery system so that their valuable resources can be utilized. And they must also be encouraged to open their doors to women in their communities who want abortions. I didn't mean to imply that health departments have no additional role in serving the unmet need. We have suggested that there's an optimum number of women who can be served efficiently, and that many health departments fall way below that level. They ought to be given the resources to expand their services and in some places to operate clinic sites in neighboring communities. We've heard a description of regionalization in Texas, and we know that it can be done, and I think there's a call to really explore this much more than we've explored it to this point. I think that came up in any number of presentations.

Who is going to identify areas with greatest needs, institute policy change, contact Planned Parenthood affiliates, community action agencies, and other agencies, draw on hospitals, assist health departments to expand and regionalize? In every state there needs to be a lead agency with a trained staff and a central locus. Many states have administrative structures wholly or partially responsible for family planning programs and wholly or partially effective. We heard about the Oklahoma and Tennessee State Health Departments, the Minnesota and Colorado statewide Planned Parenthood affiliates, the Arkansas and Illinois non-profit coordinating council. These are the three most typical models. Our discussions have suggested a number of functions these state agencies can perform given adequate staff and authority to receive and allocate funds. Spending money is not really easy. It takes skills, knowledge, sophistication and hard work. The level and quality of action at the state level is, in my mind, a major issue in the delivery of family planning services in rural America.

In the future, where will the money come from? If at least one and a half million additional nonmetropolitan women are to be served, more than 90 million dollars more will be needed over and above the 60 million dollars currently available—for a minimum total bill of 150 million dollars. No matter what title we label it, the major part will have to come from the federal government. We talked about Title X this morning. More funds have been appropriated—all we have to do is figure out how we can get our hands on it. Title XIX and Medicaid is virtually unused in nonmetropolitan areas. My back-of-the-envelope calculation showed that 36 million dollars all together could be collected for Medicaid-eligible women—six times the current (also back-of-the-envelope estimate) six million dollars. As for Title XX, I thought of one solution, and that is we could clone Lewis Mondy and make 50 of him and put one in every state! If you don't know what cloning is, what was that movie? . . . Sleeper . . . it's when you take a cell from one very desirable element and you reproduce a whole other person that's an exact replica of what you had before, only with different things programmed in—but we wouldn't want to program anything different.

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[1] A position paper about national policy and program prepared by major family planning organizations and presented to Secretary of DHEW Califano in the fall of 1977.

In the end, the discussion always comes down to money—no matter how much we care about quality and whether we like it or not. We can clearly see that the nonmetropolitan claim on scarce resources is not substantively different from the metropolitan claim. Every agency needs more money, whether it's located in the crowded central city or the wide prairie. It's evident that you family planning providers know what to do with the money when you get it, you know which program models to use and whom to train as physician equivalents; you know where you want to open clinics. Most of the requisite programs, in fact, are already in place. And whether rural or urban, what they need is more money in order to serve more people. And we also know that money doesn't grow on trees, even in the country. And it's been our experience that resources expand as the demand becomes more visible and salient.

A counterpart to official state family planning agencies are the public affairs kind of networks that are rapidly gearing up in many states. Citizen action is absolutely essential in this cause. Just during this meeting we've experienced two crises—one in the area of abortion and one in the area of dealing with the BCHS. But action is also required for less dramatic endeavors such as Title XX hearings, HSA planning committees, and as we have heard, the need for organizing consumers is particularly important in rural areas where people feel more voiceless and more invisible. I think they especially need help to convince their school boards, at least outside of Arkansas, that their children have a right to sex education in schools. Efficiency in the public sector and effectiveness of private consumer demand, I think, is a winning combination and probably necessary for producing enough resources for carrying out the requisite programs. As you can see, there's lots to do, and you're the people who will be doing it.

When we did the State Profiles for the Kellogg project, we devised a way of looking at state programs. We said the four critical components of successful efforts in family planning were non-restrictive laws and policies, efficient organization and administration, adequate funding, and leadership. All of these factors have been implicit in our discussions here. The hardest one to make explicit is leadership. We have no statistical index or no secret formula for determining its requisite incidence or prevalence, but we do know it's necessary. We believe that you are the people who are leading and will continue to lead despite the obstacles that confront you, so we hope we've given you new insights, ammunition for the daily battles you must fight for acceptance, visibility, funds, recognition, and existence. Good luck, and au revoir, and safe journey.

APPENDIX A

The Setting for Delivery of Family Planning Services in Metropolitan and Nonmetropolitan Areas

A compilation of data
prepared for the
National Conference on the Delivery
of Family Planning Services in Rural America
October 5-7, 1977
Atlanta, Georgia

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Introduction

Family planning services are provided in a variety of settings and environments in the United States and achieve varying degrees of success in serving the women who need assistance in the prevention of unwanted pregnancies. This report compiles facts and figures from many sources and presents tables and charts which provide a context for our discussion of the family planning delivery system in the more rural areas of this country.

Trends in population distribution are presented, along with data on fertility, health status indicators, health manpower resources, and health care utilization; all sources and references are listed at the end of the report. This information provides a background for understanding and interpreting the family planning and abortion service data that follows.

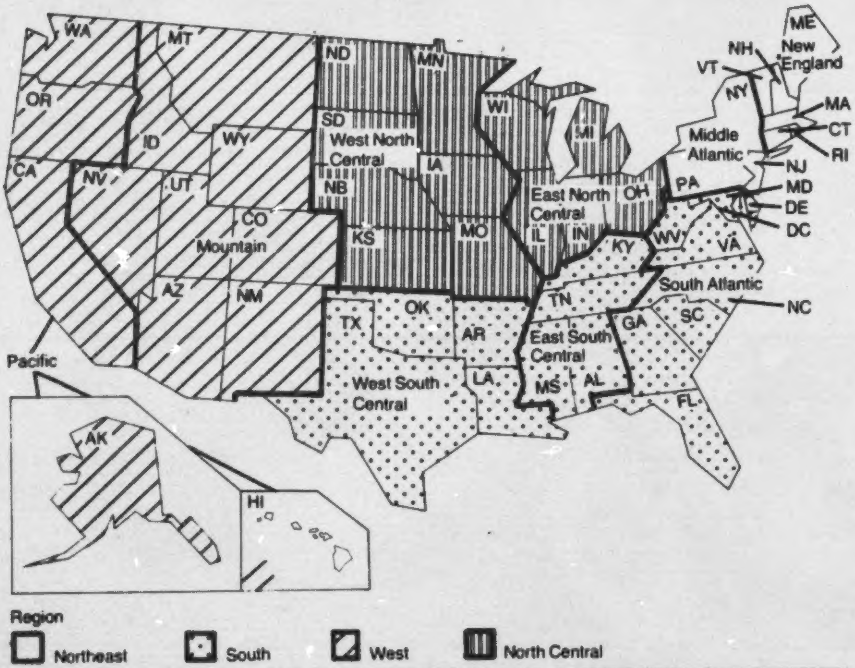
A number of interesting questions might be explored through this medium, for example:

- Is there a significant trend back to nonmetropolitan areas?
- What are the characteristics of nonmetropolitan women in their childbearing years—are they different from urban women in regard to their fertility aspirations?
- Are health resources less available in nonmetropolitan areas—and if so, how does this affect the family planning delivery system?
- Why is the gap between the need for family planning services and the number of patients served still greater in nonmetropolitan areas than in metropolitan areas?
- What is the potential role for small community hospitals in regard to abortion services and family planning care?

Summary

- 56 million people—more than one-fourth of the U.S. population—live in nonmetropolitan areas. Since 1970, the rate of growth has been greater in nonmetropolitan areas than in metropolitan areas.
- Most nonmetropolitan families live in small towns and villages; very few are still actually living on farms.
- Nonmetropolitan areas contain one-third of the white, one-fourth of the black and 18 percent of the Hispanic population. Low-income families are over-represented—41 percent of the poverty population and 34 percent of low- and marginal-income women aged 15 to 44 in need of family planning services live outside of metropolitan areas.
- Medical manpower is in short supply, the amount of preventive care is limited—yet most rural areas contain a community hospital.
- Fertility expectations are virtually the same among younger metropolitan and nonmetropolitan married women in contrast to the higher number of births expected by older nonmetropolitan wives. The "traditional" rural and urban differences are apparently disappearing.
- Birth rates are slightly higher in nonmetropolitan areas and so are crude fertility rates for non-poor women; low-income women, however, have higher levels of fertility in central cities than in nonmetropolitan areas.
- Neither organized family planning services nor abortion services are as accessible to nonmetropolitan women as they are to women residing in metropolitan areas; however, the provision of these fertility-related services appears to be expanding more rapidly outside of SMSAs.
- Of the 3.4 million nonmetropolitan low- and marginal-income women in need of family planning services, about 865,000 were patients of organized programs in 1975—thus one-fourth of the need has been served by organized programs compared to 40 percent of the metropolitan need.
- About 1.2 million sexually active teenagers live in nonmetropolitan areas (more than half are in families with low- and marginal-incomes); some 270,000 of these young people attended a family planning clinic in 1975, 23 percent of the estimated need. In metropolitan areas, 31 percent of the adolescent need was served by organized programs.
- The family planning delivery system in nonmetropolitan areas is diverse and decentralized with more than 1,400 agencies and almost 2,500 clinic locations. About two-thirds of the services are provided by local health departments, 11 percent by Planned Parenthood affiliates, four percent by hospitals and 19 percent by such other agencies as community action agencies, neighborhood health centers, and specialized family planning clinics.
- There are still 541 nonmetropolitan counties with no identifiable organized family planning clinics—78 of these counties contain more than 1,000 low- and marginal-income women in need.
- Only five percent of all legal abortions were performed in nonmetropolitan areas, and the abortion rate was one-eighth of the metropolitan area rate.

Census Regions and Divisions of the United States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Population

NEARLY THREE OUT OF 10 U.S. RESIDENTS LIVE IN NONMETROPOLITAN AREAS (TABLE 1)

- In 1974, 56 million people lived in nonmetropolitan areas which comprised 86 percent of the land area of the U.S. Almost half of the population of the West North Central and East South Central regions and one-third of the Southern population lived in nonmetropolitan areas. In the Mountain states, two-fifths of the population were nonmetropolitan residents.
- In the same year, about one person out of 23 was a farm resident, with a population of 9,264,000.
- Since 1970, 21 new counties containing 9.2 million people have been designated as parts of Standard Metropolitan Statistical Areas (SMSAs). In some cases, these people are still included in more recent counts of the nonmetropolitan population. Thus, using 1970 definitions, there would be 66 million nonmetropolitan residents, 31 percent of the U.S. population rather than 27 percent.

SINCE 1970, THE NONMETROPOLITAN POPULATION HAS GROWN FASTER THAN THE METROPOLITAN (TABLE 2)

- Between 1970 and 1976, the nonmetropolitan population grew by eight percent compared with a growth rate of four percent in metropolitan areas. Central cities lost population at a rate of three percent.
- Trends during the 1970's were markedly different from those of the previous decade. The only significant percentage increase in the metropolitan population between 1970 and 1976 has been in the black population outside central cities.
- The white nonmetropolitan population grew by nine percent between 1970 and 1976, while the black nonmetropolitan population grew by less than two percent.
- In contrast to previous decades when nonmetropolitan areas gained disproportionately in older migrants, currently people of all ages are moving to nonmetropolitan areas (not shown). The 35 to 44 age group—mainly families with children—is showing the greatest tendency to migrate to nonmetropolitan areas, while those between 20 and 24 still tend to remain in more urbanized places.

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Table 1. U.S. Population by Region and Metropolitan/Nonmetropolitan Residence, 1974 (Provisional Estimates).

Region	Population	Percent	Percent Metropolitan	Percent Non-metropolitan
Total U.S.	211,390,400	100	73	27
Northeast	49,425,700	100	86	14
New England	12,149,900	100	83	17
Middle Atlantic	37,275,800	100	87	13
North Central	57,543,900	100	69	31
East North Central	40,862,200	100	77	23
West North Central	16,681,800	100	50	50
South	67,177,300	100	64	36
South Atlantic	33,206,300	100	66	34
East South Central	13,387,000	100	52	48
West South Central	20,584,000	100	68	32
West	37,243,700	100	80	20
Mountain	9,410,400	100	61	39
Pacific	27,833,300	100	87	13

Source: 1

Table 2. Population of the United States by Metropolitan*-Nonmetropolitan Residence and Color, 1976 and 1970 (numbers in 000's).

Race and Residence	1976	Change, 1970 to 1976	Percent Change	
			1970 to 1976	1960 to 1970
All Races	210,332	10,513	5.3	13.3
Metropolitan Areas	142,567	5,509	4.0	16.6
In Central Cities	60,730	−2,146	−3.4	6.5
Outside Central Cities	81,837	7,655	10.3	26.7
Nonmetropolitan Areas	67,765	5,004	8.2	6.8
White	182,638	7,362	4.2	11.9
Metropolitan Areas	121,392	2,454	2.1	14.0
In Central Cities	45,215	−3,694	−7.6	0.1
Outside Central Cities	76,177	6,148	8.8	26.1
Nonmetropolitan Areas	61,246	4,908	8.7	7.8
Black and Other Races	27,694	3,151	12.8	24.3
Metropolitan Areas	21,175	3,055	16.9	36.9
In Central Cities	15,515	1,548	11.1	36.5
Outside Central Cities	5,660	1,507	36.3	38.1
Nonmetropolitan Areas	6,519	96	1.5	−1.6

*Metropolitan as defined in 1970.
Source: 2

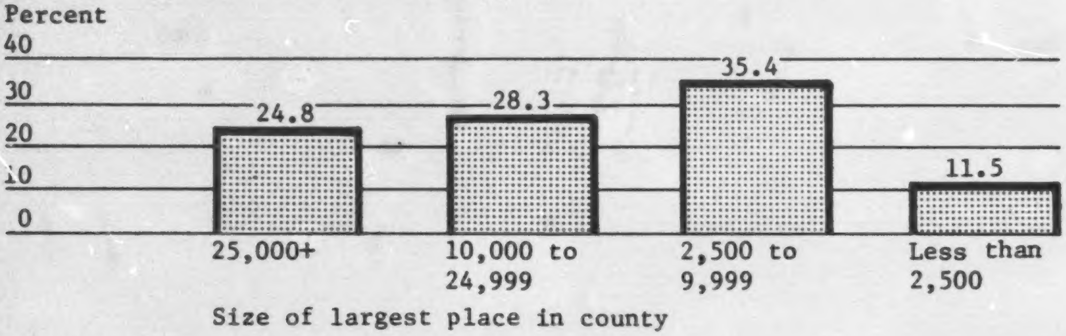
ALMOST EIGHT MILLION U.S. RESIDENTS LIVE IN COUNTIES WITH NO TOWN OF 2,500 OR MORE PEOPLE (FIGURE 3)

- In 1974, about 11 percent of the nonmetropolitan population, or about 7.6 million persons, lived in rural counties with no place (city, town or village) of 2,500 or more residents.
- More than one-third (18.6 million) of the nonmetropolitan residents lived in counties with a place of 2,500 to 10,000 people, the next largest size-of-place category.
- The distribution of the population *within* nonmetropolitan counties has not changed significantly since 1970; in-migration has been evenly distributed by size of place.
- More than half of all nonmetropolitan residents (about 30 million) live in counties adjacent to an SMSA, while 12 percent (8.6 million) live in areas defined as "totally rural."

WHITE POPULATION MOST LIKELY TO BE RURAL RESIDENTS (FIGURE 4)

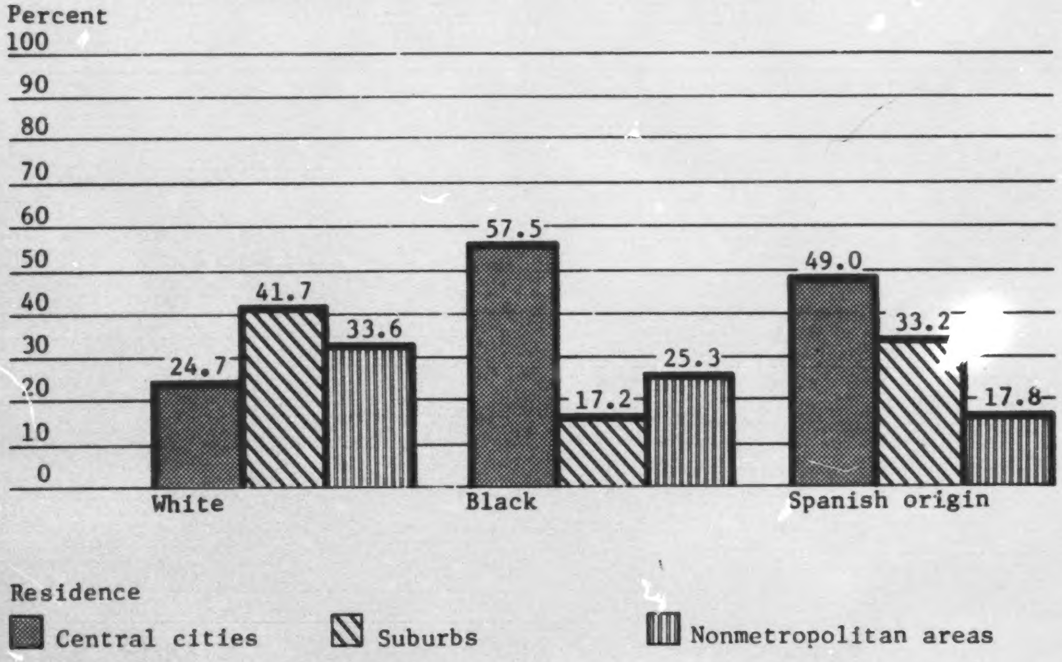
- While only one-quarter of the U.S. white population lived in central cities in 1976, almost three-fifths of the black and one-half of the Hispanic population were inner-city residents.
- Of the three groups, white persons were most likely to be rural residents; nonmetropolitan areas contained one-third of the white, one-quarter of the black and 18 percent of the Hispanic population.
- White persons were also more likely to live in suburbs than either of the groups (42 percent), but one-third of Hispanic persons were suburban residents, compared with only 17 percent of black persons.

Figure 3. Percent distribution of nonmetropolitan population by size of largest place in county; 1974



Source: 3

Figure 4. Percent distribution of type of residence by color and spanish origin: 1975



Source: 4

MORE THAN 15 PERCENT OF THE NONMETROPOLITAN POPULATION IS BELOW THE POVERTY LEVEL (TABLE 5)

- In 1975, 12 percent of the total U.S. population, or 25.9 million persons, had incomes below the federal poverty level ($5,500 for a nonfarm family of four). There is a marked color differential in the proportion of persons below the poverty level with 10 percent of the white population and almost one-third of the black population below the poverty level.
- In nonmetropolitan areas, more than 15 percent of the population was below the poverty level, compared to almost 11 percent in metropolitan areas. (Nonmetropolitan areas and central cities contain about equal percentages of residents below the poverty level.) Although the percentage of the population in poverty in nonmetropolitan areas and central cities is similar, a larger percentage of blacks in nonmetropolitan areas are poor (42 percent compared to 29 percent in central cities); for whites, the difference is much less (13 percent in nonmetropolitan counties and 11 percent in central cities).
- Although metropolitan-nonmetropolitan poverty differentials remain, the proportion of nonmetropolitan residents living in poverty declined between 1970 and 1975, from 17 percent to 15.4 percent, while the poverty rate in metropolitan areas rose slightly, from 10.2 percent to 10.8 percent.

NONMETROPOLITAN RESIDENTS ARE DISPROPORTIONATELY POOR (FIGURE 6)

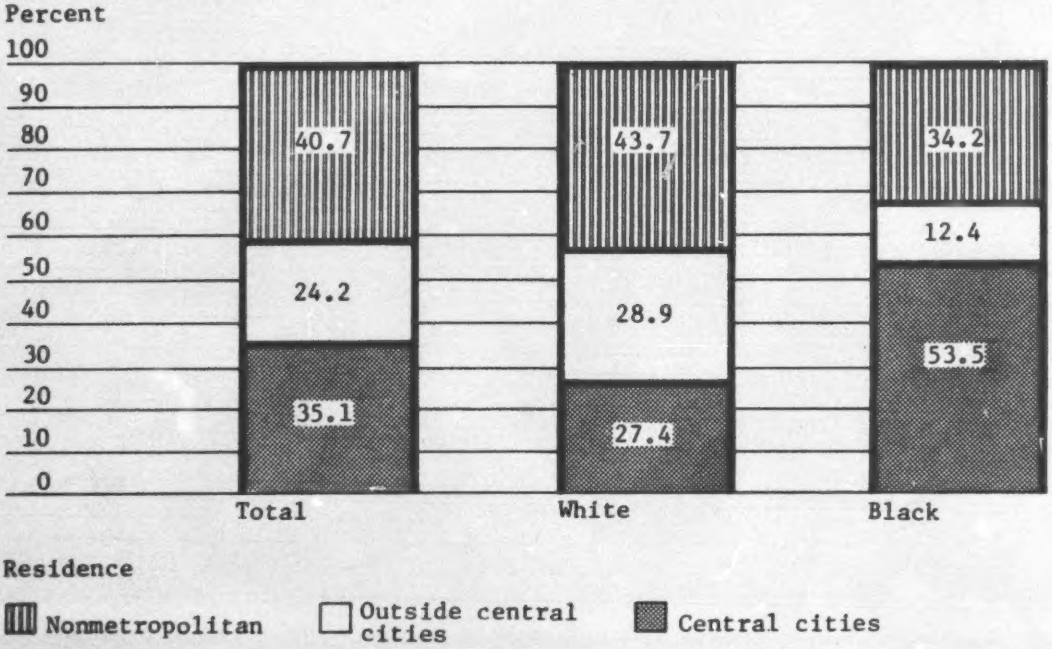
- Nonmetropolitan areas contained 31 percent of the U.S. population (using 1970 definitions), but had 41 percent of persons below the poverty level.
- Low-income white persons are more likely to live in nonmetropolitan areas; 44 percent of all white families below poverty were living outside SMSAs.
- While a majority of the poor black population lives in central cities, a disproportionate number of black families in nonmetropolitan areas are poor. Thirty-four percent of all black persons below the poverty level were nonmetropolitan residents.

Table 5. Metropolitan*-Nonmetropolitan Residence-Persons by Poverty Status and Color, 1975 (numbers in 000's).

				White			Black		
		Below Poverty Level			Below Poverty Level			Below Poverty Level	
	Total Population	Number	Percent of Total Population	Total Population	Number	Percent of Total Population	Total Population	Number	Percent of Total Population
All Persons	210,864	25,877	12.3	183,164	17,770	9.7	24,089	7,545	31.3
Metropolitan Areas	142,658	15,348	10.8	121,621	10,014	8.2	18,006	4,967	27.6
Inside Central Cities	60,695	9,090	15.0	45,217	4,874	10.8	13,858	4,033	29.1
Outside Central Cities	81,963	6,259	7.6	76,404	5,139	6.7	4,148	934	22.5
Nonmetropolitan Areas	68,206	10,529	15.4	61,543	7,757	12.6	6,083	2,578	42.4

*Metropolitan as defined in 1970.
Source: 4

Figure 6. Percent distribution of persons below the poverty level, by color and residence, 1975



Source: 4

MORE THAN ONE-THIRD OF ALL LOW-INCOME WOMEN IN THEIR CHILDBEARING YEARS LIVE IN NONMETROPOLITAN AREAS (TABLE 7)

- Of the 46.5 million women aged 15 to 44 in 1975, about 14 million (30 percent) live in nonmetropolitan areas.
- About 3.4 million low-income* women in their childbearing years live in nonmetropolitan areas; they comprise 36 percent of all low-income women and 24 percent of all nonmetropolitan women in their age group.
- Among women aged 15 to 44, a significantly smaller proportion of those below 150 percent of poverty are currently married; in nonmetropolitan areas less than half are married compared to two-thirds of the higher income women.
- A much higher proportion of low-income nonmetropolitan women are separated or divorced; one-fifth of them are previously married compared to only four percent of higher income nonmetropolitan women.

*Low income = with incomes below 150 percent of poverty or $8,250 for a family of four during 1975.

ALMOST ONE MILLION LOW-INCOME FEMALE TEENAGERS LIVE IN NONMETROPOLITAN AREAS (TABLE 8)

- Of the 10.2 million U.S. female teenagers, 3.3 million live in nonmetropolitan areas, almost a million of whom are in low-income families. More than 39 percent of nonmetropolitan teens are poor compared to 30 percent of metropolitan teens.
- About 42 percent of low-income white teenagers are nonmetropolitan residents as compared to 32 percent of low-income nonwhite teenagers, 31 percent of higher income white teenagers and 20 percent of higher income nonwhite teenagers.

Table 7. Distribution of Women Aged 15-44 by Metropolitan/Nonmetropolitan Residence, Poverty Status, and Marital Status, 1975 (numbers in 000's).

Poverty Status	Total Number	Percent by Marital Status			
		Total	Currently Married	Previously Married	Single
Total	46,542	100	57	10	33
Below 150 Percent of Poverty	9,366	100	36	26	38
Above 150 Percent of Poverty	37,176	100	63	6	31
Metropolitan Total	32,461	100	55	11	34
Below 150 Percent of Poverty	5,955	100	31	30	40
Above 150 Percent of Poverty	26,506	100	61	7	32
Nonmetropolitan Total	14,081	100	62	8	30
Below 150 Percent of Poverty	3,411	100	46	20	34
Above 150 Percent of Poverty	10,670	100	67	4	29

Source: 5

Table 8. Distribution of Women Above and Below 150 Percent of Poverty by Age, Color and Nonmetropolitan Residence, 1975 (numbers in 000's).

Color and Age	Above 150 Percent of Poverty			Below 150 Percent of Poverty		
	Total Number	Residents of Nonmetropolitan Areas		Total Number	Residents of Nonmetropolitan Areas	
		Number	Percent		Number	Percent
Total 15-44	37,176	10,670	29	9,366	3,411	36
15-19	7,761	2,344	30	2,444	950	39
20-29	14,213	3,964	28	3,538	1,196	34
30-44	15,203	4,363	29	3,383	1,264	37
White 15-44	33,574	10,105	30	6,465	2,548	39
15-19	7,043	2,201	31	1,599	676	42
20-29	12,778	3,741	29	2,514	900	36
30-44	13,753	4,163	30	2,352	972	41
Nonwhite 15-44	3,603	566	16	2,900	863	30
15-19	718	142	20	845	275	32
20-29	1,435	224	16	1,024	296	29
30-44	1,451	199	14	1,030	293	28

Source: 5

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INFANT AND NEONATAL MORTALITY RATES ARE HIGHER IN NONMETROPOLITAN COUNTIES (TABLE 9)

- Infant and neonatal mortality rates are slightly higher in nonmetropolitan counties than in metropolitan counties, for both whites and nonwhites. The metropolitan/nonmetropolitan difference is greater for nonwhites, who also have much higher infant mortality rates than do whites. All counties with an infant mortality rate of at least twice the national rate are nonmetropolitan.
- The lowest death rates for both groups are in nonurban parts of metropolitan counties (suburbs), while the highest rates are generally in urban parts of nonmetropolitan counties.
- In 1972, nonmetropolitan counties showed a slightly higher rate of maternal mortality than did metropolitan counties (22.15 compared to 18.75 per 100,000 live births).

NONMETROPOLITAN WOMEN IN THEIR CHILDBEARING YEARS MADE SIGNIFICANTLY FEWER OFFICE VISITS (TABLE 10)

- U.S. women made, on the average, 3.7 visits to physicians offices in 1974; but nonmetropolitan women made only 2.9 visits compared to 4.0 visits made by metropolitan women.
- The younger the nonmetropolitan women, the fewer the office visits they made; however, the most significant difference was between metropolitan and nonmetropolitan women aged 25 to 44—the prime years for family planning care. Nonmetropolitan women made 1.9 office visits less than metropolitan women.
- About 25 percent of all office visits made by males and females were in nonmetropolitan areas; by type of practice, this included 38 percent of all general and family practice physician office visits and only 10 percent of all ob/gyn office visits.

NONMETROPOLITAN WOMEN RECEIVE LESS PREVENTIVE HEALTH CARE (TABLE 11)

- Women in nonmetropolitan areas tend to receive less preventive health care than metropolitan women. Twenty-four percent of women over 17 outside SMSA's had had neither a breast examination, nor a Pap smear. For metropolitan women, 17 percent had never had a breast examination and 19 percent had never had a Pap smear. The proportion of nonmetropolitan farm women who had never had either examination was even higher (28 percent) than for non-farm women outside metropolitan areas.
- Women in metropolitan areas also receive prenatal care somewhat earlier than nonmetropolitan women (not shown). Although 99 percent of women having live births were seen by a doctor before delivery in all areas of residence, 20 percent of nonmetropolitan women did not see a doctor before the fourth month of pregnancy, compared to 15 percent of metropolitan women. However, there was no metropolitan/nonmetropolitan difference in the percent receiving a postnatal checkup (approximately 84 percent).

Health Status Indicators and Health Resources

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Table 9. Infant and Neonatal Mortality Rates by Metropolitan and Urban* Status, for Whites and Nonwhites, U.S., 1973.

	<1 Year			<28 Days		
Residence	Total	White	Nonwhite	Total	White	Nonwhite
U.S. Total	17.7	15.8	26.2	13.0	11.8	17.9
Metropolitan Counties	17.2	15.1	25.1	12.7	11.4	17.8
Urban	18.2	15.7	25.4	13.4	11.8	18.1
Nonurban	14.8	14.1	22.8	10.9	10.5	15.2
Nonmetropolitan Counties	18.8	17.0	29.2	13.6	12.8	18.0
Urban	19.8	18.0	28.8	14.6	13.6	19.5
Nonurban	18.6	16.7	29.4	13.3	12.5	17.5

*Urban places in metropolitan counties are those with populations of 10,000 or more; urban places in nonmetropolitan counties are those with populations of 10,000 to 50,000.

Source: 6

Table 10. Annual Rate of Office Visits by Age of Female Patients, Metropolitan and Nonmetropolitan Areas, 1973-1974.

	Number of Visits Per Female Per Year	
Age	Metropolitan	Nonmetropolitan
Total	4.0	2.9
Under 15	2.3	1.9
15-24	3.7	2.8
25-44	4.7	2.8
45-64	4.8	3.2
65 +	5.6	4.5

Source: 7

Table 11. Percent of Females 17 Years and Over Never Having a Breast Exam and Percent Never Having a Pap Smear, by Residence, U.S., 1973.

	Percent	
Place of Residence	Never Had Breast Exam	Never Had Pap Smear
Total	19.4	21.0
SMSA	17.4	19.5
Central City	18.1	20.5
Not Central City	16.8	18.7
Outside SMSA	23.9	24.3
Nonfarm	23.3	23.8
Farm	28.3	28.4

Source: 8

CHILDREN IN NONMETROPLITAN COUNTIES RECEIVE FEWER ROUTINE PHYSICAL EXAMINATIONS (TABLE 12)

- Children under 17 years outside metropolitan areas also receive less preventive health care: the metropolitan/nonmetropolitan differential is greater for children than for adult females. In metropolitan areas, eight percent of children had never had a routine physical examination, compared to 14 percent outside SMSA's.
- Regional differences are also apparent: in the South, almost 16 percent of persons under 17 had never had a routine physical examination, while only five percent of these youth in the Northeast had never had one.

THERE ARE TWICE AS MANY PERSONS PER PHYSICIAN IN NONMETROPOLITAN AS IN METROPOLITAN AREAS (TABLE 13)

- In 1974, there were 764 persons per active practitioner in the U.S. There were nearly twice as many persons per physician in nonmetropolitan counties (1,299) as there were in metropolitan counties (673).
- Almost half of the physicians in nonmetropolitan areas were offering office-based *primary care* compared to less than one-third of metropolitan area physicians.
- Physicians in rural areas tend to be older. Those who die or retire from practice are not being replaced proportionately.
- The proportion of physicians who are involved in primary care is declining. Because specialists tend to practice in urban areas, this leaves relatively fewer physicians in rural areas. During the past 10 years, the number of general practitioners declined by 27 percent, while the number of specialists increased by 44 percent. Ten years ago, metropolitan areas attracted almost 84 percent of physicians; they now attract more than 86 percent.

Table 12. Number and Percent of Persons Under 17 Years Never Having a Routine Physical Examination According to Selected Characteristics, United States, Based on Data Collected in Health Interviews in 1973 (numbers in 000's).

Characteristic	Never Had Routine Physical Examination	
	Number	Percent
Geographic Region		
Northeast	732	5.0
North Central	1,104	6.2
South	3,229	15.6
West	1,199	10.8
Place of Residence		
SMSA	3,405	7.8
Central City	1,626	8.8
Not Central City	1,779	7.1
Outside SMSA	2,860	14.0
Nonfarm	2,518	13.8
Farm	342	15.8

Source: 8

Table 13. U.S. Ratios of Population to Active Non-Federal Physicians in Metropolitan/Nonmetropolitan Counties, 1974.

Type of County	Active Practitioners	Persons Per Active Practitioner
Patient Care, 1974:		
All Counties	276,070	764
Metropolitan	235,994	673
Nonmetropolitan	40,076	1,299
Office-based, 1973:		
All Counties	197,644	1,060
Metropolitan	166,123	923
Nonmetropolitan	31,521	1,778
Office-based Primary Care, 1973:		
All Counties	97,643	2,145
Metropolitan	77,815	1,971
Nonmetropolitan	19,828	2,827

Source: 9

AS COUNTY POPULATION SIZE INCREASES, THE NUMBER OF PERSONS PER PHYSICIAN DECREASES (FIGURE 14)

- In the largest counties, with 100,000 or more population, there are 636 persons per physician as compared to smaller counties with 10,000 or less population which almost all have 2,500 or more persons per physician.
- This same differential exists between counties for physicians engaged in primary care.
- In the smallest counties, almost all physicians are engaged in patient care, and most are office-based general practitioners; e.g., in counties with less than 10,000 population, there are 310,000 persons per ob/gyn.
- For all of the primary care specialities except general practice, there are more than twice as many persons per active practitioner in nonmetropolitan than in metropolitan counties.

IN ALL REGIONS, NONMETROPOLITAN AREAS HAVE RELATIVELY FEWER PRACTICING REGISTERED NURSES (TABLE 15)

- In the nonmetropolitan areas of the West South Central region of the U.S., there are only 14 registered nurses per 10,000 population, just about half of the ratio prevailing in metropolitan areas.
- No region has a higher ratio in its nonmetropolitan areas than its metropolitan areas, but the gap appears to be greatest in the West North Central region.
- New England states appear to have substantially greater numbers of practicing registered nurses per 10,000 population than elsewhere.

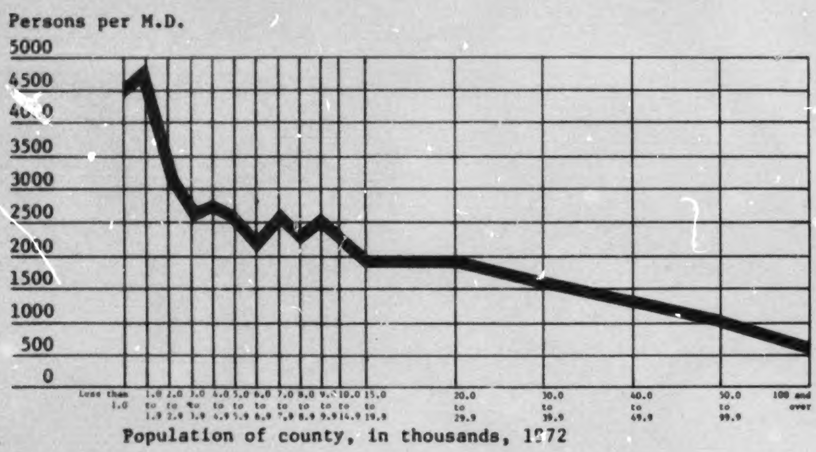
MORE THAN HALF OF ALL U.S. HOSPITALS ARE IN NONMETROPOLITAN AREAS (TABLE 16)

- Of 5,820 U.S. general hospitals, 52 percent were located in nonmetropolitan areas (according to 1968 definitions).
- The smaller the hospital, the more likely it was to be located in a nonmetropolitan county: 70 percent of hospitals with under 100 beds are located outside of SMSAs.
- Virtually all large non-federal short term hospitals are located in metropolitan areas.
- In 1970, metropolitan area residents averaged 767 outpatient visits in hospitals per 1,000 population compared to 429 per 1,000 in nonmetropolitan areas. Nonmetropolitan area residents accounted for 22 percent of outpatient visits (33 percent of the population at that time).

Ratio of Persons Per M.D. in Nonmetropolitan Areas to Persons Per M.D. in Metropolitan Areas

Specialty	Ratio
TOTAL PRIMARY CARE	1.29
General Practice	.75
Internal Medicine	2.76
Pediatrics	2.59
Obstetrics/Gynecology	2.58

Figure 14. Persons per primary care practitioner by county size, 1973



Source:9

Table 15. Number of Practicing Registered Nurses Per 10,000 Population by Metropolitan/Nonmetropolitan Status, for Census Regions, 1975.

Region and Metropolitan Status	RN's Per 10,000 Population	Region and Metropolitan Status	RN's Per 10,000 Population
New England		East South Central	
Metropolitan	62.2	Metropolitan	28.7
Nonmetropolitan	51.3	Nonmetropolitan	16.6
Middle Atlantic		West South Central	
Metropolitan	43.6	Metropolitan	26.5
Nonmetropolitan	42.3	Nonmetropolitan	14.0
East North Central		Mountain	
Metropolitan	38.7	Metropolitan	41.5
Nonmetropolitan	32.3	Nonmetropolitan	31.4
West North Central		Pacific	
Metropolitan	47.9	Metropolitan	35.0
Nonmetropolitan	32.6	Nonmetropolitan	29.0
South Atlantic			
Metropolitan	36.9		
Nonmetropolitan	23.6		

Source: 10

Table 16. Community Hospitals in Metropolitan/Nonmetropolitan Areas, by Size of Hospital, U.S., 1968.

Size of Hospital	All Hospitals	Percent Located in Metropolitan Areas	Percent Located in Nonmetropolitan Areas
Total	5,820	48	52
Less than 25	445	29	71
25- 49	1,396	23	77
50- 99	1,477	36	64
100-199	1,232	57	43
200-299	566	77	23
300-399	335	90	10
400-499	169	94	6
Over 500	201	99	1

Source: 11

Fertility

BIRTH EXPECTATIONS AMONG YOUNGER WIVES ARE SIMILAR REGARDLESS OF RESIDENCE (TABLE 17)

- Metropolitan wives expected an average of 2.4 births, while nonmetropolitan wives expected 2.5 births in 1976.
- Among the youngest wives—aged 18 to 24—metropolitan wives expected slightly larger families than their nonmetropolitan counterparts.
- The older the women, the greater the differential between nonmetropolitan and metropolitan residents both in terms of expected family size and of number of children born.

SINGLE WOMEN OF ALL AGES RESIDING IN NONMETROPOLITAN AREAS EXPECT SMALLER FAMILIES (TABLE 18)

- Single women appear to expect about 1.8 births during their childbearing years regardless of residence.
- Unlike married women, the older the single women, the lower their birth expectations.
- In nonmetropolitan areas, single women consistently expect smaller families than metropolitan women.

CRUDE FERTILITY RATES ARE SOMEWHAT HIGH IN NONMETROPOLITAN AREAS (FIGURE 19)

- A crude fertility rate by residence and poverty status can be calculated from census survey data using the ratio of the number of children under three years old per 1,000 women aged 15 to 44 years old. For all such women, in 1976, the ratio was 191 for the three years, or about 64 births per 1,000 women for one year.
- This ratio was also 191 for nonmetropolitan women in families above 150 percent of poverty and 299 for nonmetropolitan low-income women. The differential was even greater in the central cities, where the ratio was 172 for women above 150 percent of poverty and 302 for those below.
- As would be expected, the ratio was the lowest in the noncentral city (suburban) metropolitan areas: 171 for women above the poverty level, and 262 for those below it.
- Some children under three live with families other than their parents; this could affect the distribution by poverty status and place of residence slightly.

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Table 17. Average Births to Date, and Lifetime Births Expected,* by Metropolitan/Nonmetropolitan Residence and Age Group, for Wives 18-39, June 1976.

Residence and Age	Births to Date	Lifetime Births Expected	Percent of Expected Fertility Completed
Metropolitan			
Total 14-39	1,823	2,404	76
18-24	770	2,155	36
25-29	1,495	2,167	69
30-34	2,274	2,468	92
35-39	2,855	2,897	99
Nonmetropolitan			
Total 14-39	1,978	2,514	79
18-24	896	2,118	42
25-29	1,727	2,275	76
30-34	2,533	2,668	95
35-39	3,175	3,204	99

*Per 1,000 wives who reported on birth expectations.

Source: 12

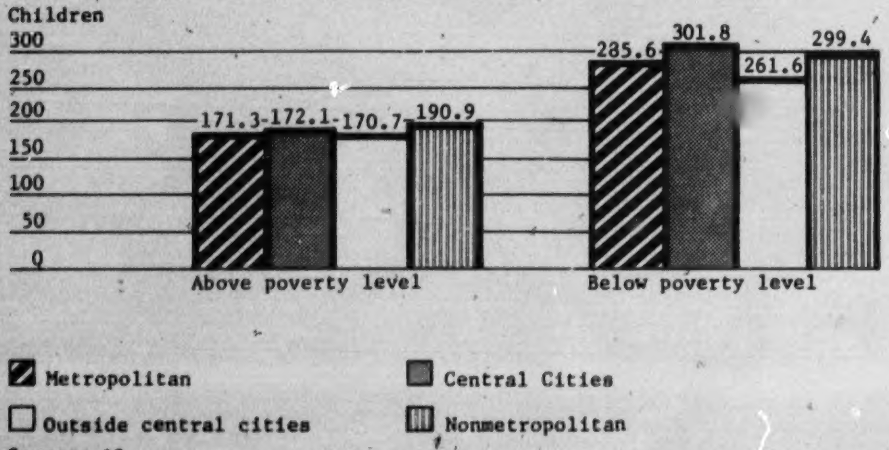
Table 18. Average Lifetime Births Expected* by Metropolitan/Nonmetropolitan Residence and Age for Single Women, June 1976.

Age	Residence	
	Metropolitan	Nonmetropolitan
Total 18-34	1,794	1,793
18-19	2,105	1,985
20-21	1,868	1,832
22-24	1,787	1,758
25-29	1,425	1,414
30-34	946	903

*Per 1,000 single women who reported on birth expectations.

Source: 12

Figure 19. Children under 3 years old per 1000 women 15-44, by poverty status in 1975 and residence, March 1976



Source: 13

BIRTH RATES IN NONMETROPOLITAN AREAS ARE HIGHER IN MOST PARTS OF THE U.S. (TABLE 20)

- Although the birth rate in the U.S. as a whole is low, and has been declining, wide variation among states and regions remains. Table 20 shows estimates of the birth rates of metropolitan and nonmetropolitan areas by census region for 1975. The overall metropolitan area birth rate is 14.5 per 1,000 population, while in nonmetropolitan areas it is 15.6 per 1,000.
- Of the nine census regions, six have a nonmetropolitan birth rate that is at least 1.0 per 1,000 population higher than the metropolitan rate.
- The Northeastern states have the lowest birth rates of any part of the country in both metropolitan and nonmetropolitan areas and the Mountain states show the highest birth rates of any region in the country, with significant variations among states. In the West South Central region, the birth rate in 1975 was higher in metropolitan than in nonmetropolitan areas.
- Since birth rates reflect the age composition of the population, states or areas with older populations may have lower birth rates but not necessarily lower fertility rates.

Table 20. Number of Births and Birth Rates by Census Region and Metropolitan Status, U.S., 1975.

Census Region	Number of Births	Birth Rate*
U.S. Total	3,134,439	14.8
Metropolitan	2,094,340	14.5
Nonmetropolitan	1,040,099	15.6
New England	148,024	12.2
Metropolitan	107,741	11.8
Nonmetropolitan	40,283	13.6
Middle Atlantic	477,114	12.8
Metropolitan	387,009	12.7
Nonmetropolitan	90,105	13.0
East North Central	609,690	14.9
Metropolitan	443,863	14.6
Nonmetropolitan	165,827	15.8
West North Central	245,750	14.7
Metropolitan	118,663	14.7
Nonmetropolitan	127,087	14.8
South Atlantic	472,614	14.6
Metropolitan	257,269	14.1
Nonmetropolitan	215,345	15.2
East South Central	218,920	16.4
Metropolitan	88,392	15.8
Nonmetropolitan	130,528	16.8
West South Central	360,749	17.5
Metropolitan	236,984	18.1
Nonmetropolitan	123,765	16.5
Mountain	176,801	18.8
Metropolitan	98,941	18.2
Nonmetropolitan	77,860	19.6
Pacific	424,777	15.3
Metropolitan	355,478	15.1
Nonmetropolitan	69,299	16.4

*Births per 1,000 population.

Source: 14

Family Planning Services

ABOUT 2.5 MILLION NONMETROPOLITAN LOW- AND MARGINAL-INCOME WOMEN IN NEED DID NOT USE ORGANIZED CLINIC SERVICES IN 1975 (TABLE 21)

- More than 3.4 million low- and marginal-income women* were in need of organized family planning services in nonmetropolitan areas in 1975, 34 percent of all such women.
- Only one-fourth of all low- and marginal-income patients lived in nonmetropolitan areas, accounting for 865,000 patients (an estimated 89 percent of 967,000 nonmetropolitan patients were in families with incomes below 200 percent of poverty).
- The number of nonmetropolitan women in need who were not served by organized programs was large—in excess of 2.5 million, two out of five of all unserved women in need.
- As a result, 75 percent of all low- and marginal-income nonmetropolitan women in need were unserved compared to 60 percent of like metropolitan women. It is possible that 700,000 to one million of the unserved women (20-30 percent of the need) used private physicians for their family planning care.

*Low- and marginal-income women = women in families with incomes of 200 percent of poverty or less ($11,000 for a family of four in 1975).

FEWER THAN ONE-FOURTH OF THE TEENAGERS AT RISK WERE SERVED BY ORGANIZED PROGRAMS IN 1975 (TABLE 22)

- Of the four million teenagers at risk of unintended pregnancy in 1975, almost 1.2 million (28 percent) lived in nonmetropolitan areas.
- About 270,000 patients aged 15 to 19 attended clinics in nonmetropolitan counties during the year, 23 percent of all teen patients.
- Relating need to services, 77 percent of all nonmetropolitan teenagers in need of family planning services remained unserved in 1975 compared to 69 percent of the metropolitan teen population.
- As a result, about 882,000 sexually active adolescents did not use organized clinic facilities in nonmetropolitan areas; the proportion who used private physicians for their family planning care is unknown.
- About 520,000 adolescents, 45 percent of the nonmetropolitan teenagers in need, are in families with incomes above 200 percent of poverty; the incomes of the teenage family planning caseload are not known. The total need for organized services in nonmetropolitan areas among low- and marginal-income women and high income teens is almost four million.

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Table 21. Number of Low- and Marginal-Income Women Aged 15-44 At Risk of Unwanted and/or Unplanned Pregnancy (Need), Number and Percent Served and Unserved by Organized Programs, by Metropolitan Status, 1975 (numbers in 000's).

	Need		Organized Family Planning Services		Unserved		Percent	
	Number	Percent	Number	Percent	Number	Percent	Served	Unserved
Total	9,906	100	3,461	100	6,460	100	35	65
Metropolitan	6,497	66	2,596	75	3,905	60	40	60
Nonmetropolitan	3,412	34	865	25	2,554	40	25	75

Source: 15

Table 22. Number of Women Aged 15-19 At Risk of Unintended Pregnancy (Need), and Number and Percent Served and Unserved, by Metropolitan Status, 1975 (numbers in 000's).

	Need		Served by Organized Programs		Unserved		Percent	
	Number	Percent	Number	Percent	Number	Percent	Served	Unserved
Total	4,076	100	1,175	100	2,901	100	29	71
Metropolitan	2,924	72	905	77	2,019	70	31	69
Nonmetropolitan	1,152	28	270	23	882	30	23	77

Source: 16

FAMILY PLANNING SERVICES HAVE INCREASED RELATIVELY MORE IN NONMETROPOLITAN AREAS (TABLE 23)

- The total number of family planning patients in nonmetropolitan areas (regardless of income) has increased more than seven-fold since 1968, from 144,000 to almost one million.
- Metropolitan areas experienced a larger numerical increase, but services grew at a slower rate.
- While the nonmetropolitan caseload now comprises one-fourth of the total, in 1968, only 17 percent of all family planning patients resided in nonmetropolitan areas.

ALMOST FOUR OUT OF FIVE NONMETROPOLITAN COUNTIES CONTAIN AN ORGANIZED FAMILY PLANNING PROGRAM (TABLE 24)

- In 1975, only in 541 nonmetropolitan counties were there no identifying organized family planning programs; this represented about one-fifth of all nonmetropolitan counties.
- Of the nonmetropolitan counties with no known clinics, 78 have more than 1,000 women in need, and 151 have 500 to 1,000 women in need. Large counties with no organized family planning services are heavily concentrated in the East and West North Central states, around the Great Lakes and beyond—but they are also found in such diverse states as Pennsylvania and Texas.
- The greater the number of women in need in the county, the more likely that the county had available family planning services: in almost all counties with more than 2,000 women in need there was a program. In more than three-quarters of the counties with less than 200 in need, no program could be identified.

Table 23. Distribution of U.S. Family Planning Caseload by Metropolitan Status, Selected Years, 1968 to Present (numbers in 000's).

	Number of Patients			Percent	
	Total	Metropolitan	Nonmetropolitan	Metropolitan	Nonmetropolitan
FY 1968	863	719	144	83	17
CY 1969	1,070	877	193	82	18
FY 1971	1,889	1,518	371	80	20
FY 1974	3,272	2,555	727	78	22
FY 1975	3,813	2,9[illegible]	874	77	23
CY 1975	3,924	2,955	969	75	25

NB: Definitions of metropolitan counties have been changed during the course of data collection.
Source: 15

Table 24. Total Number of U.S. Nonmetropolitan Counties and Number Without Organized Family Planning Services by Numbers of Women in Need in County, 1975.

	Nonmetropolitan		
		Counties with No Organized Service	
Number of Women in Need in County	Total Counties	Number	Percent
Total	2,441	541	22
1-99	44	39	89
100-199	107	81	76
200-299	116	65	56
300-499	319	127	40
500-999	656	151	23
1,000-1,999	671	61	9
2,000-2,999	277	10	4
3,000-4,999	186	7	4
5,000-9,999	56	0	0
10,000-19,999	3	0	0

Source: 15

THE RESIDENTIAL DISTRIBUTION OF THE WOMEN IN NEED AND THE FAMILY PLANNING CASELOAD DIFFERS SIGNIFICANTLY BY REGION (TABLE 25)

- The metropolitan/nonmetropolitan distribution of low- and marginal-income women in need of family planning services by regions is significantly different: the Northeast contains almost one-fourth of the metropolitan need and only 10 percent of the nonmetropolitan need while the South contains about one-third of the metropolitan need and half of the nonmetropolitan need.
- Almost half a million women in need live in the nonmetropolitan counties of five of the nine census regions.
- Service patterns are equally uneven. More than 61 percent of nonmetropolitan area patients live in the South as compared to 35 percent of metropolitan area patients. The Northeast contains only nine percent of all nonmetropolitan area patients but 24 percent of metropolitan area patients.

ABOUT ONE-FOURTH OF NONMETROPOLITAN WOMEN IN NEED HAVE BEEN SERVED COMPARED TO TWO-FIFTHS OF METROPOLITAN AREA WOMEN IN NEED (TABLE 26)

- The highest proportion of the need served by organized programs in nonmetropolitan areas (38 percent) was in the Pacific region and the lowest proportion (12 percent) was in the East North Central.
- Little relationship was shown between high service levels in nonmetropolitan areas and high service levels in metropolitan areas. In the West North Central area only 14 percent of the nonmetropolitan need was served compared to almost half of the metropolitan need.
- The percent of the need not served (the reciprocal of the percent of the need served) was more than 80 percent in three of the nine census regions—the Middle Atlantic, East and West North Central. Large rural areas in the midwest have the least accessible family planning services in the U.S.

Table 25. Number of Low- and Marginal-Income Women Aged 15-44 in Need and Number Served by Organized Programs by Metropolitan/Nonmetropolitan Residence and Census Region, 1975 (numbers in 000's).

Region	Women 15-44 in Need				Family Planning Services			
	Metropolitan Number	Nonmetropolitan Number	Percent of Metropolitan Total	Percent of Nonmetropolitan Total	Metropolitan Number	Nonmetropolitan Number	Percent of Metropolitan Total	Percent of Nonmetropolitan Total
U.S. Total	6,497	3,412	100	100	2,598	865	100	100
Northeast	1,568	356	24.1	10.4	613	77	23.7	8.8
New England	326	121	5.0	3.5	116	35	4.5	4.0
Middle Atlantic	1,242	235	19.1	6.9	497	42	19.2	4.8
North Central	1,469	892	22.6	26.1	522	118	20.1	13.7
East North Central	1,130	435	17.4	12.7	356	53	13.7	6.1
West North Central	339	457	5.2	13.4	166	65	6.4	7.6
South	2,224	1,742	34.3	51.1	916	532	35.2	61.5
South Atlantic	999	780	15.4	22.9	429	242	16.5	28.0
East South Central	416	497	6.4	14.6	173	162	6.6	18.7
West South Central	809	464	12.5	13.6	314	128	12.1	14.8
West	1,236	421	19.0	12.3	546	137	21.0	16.0
Mountain	262	227	4.0	6.6	119	64	4.6	7.5
Pacific	974	134	15.0	5.7	427	73	16.4	8.5

Source: 15

Table 26. Percent of Low- and Marginal-Income Women Aged 15-44 in Need Who Were Served and Not Served by Organized Programs, by Census Regions, 1975.

Region	Percent of Need Served		Percent of Need Not Served	
	Metropolitan	Nonmetropolitan	Metropolitan	Nonmetropolitan
U.S. Total	40.0	25.4	60.0	74.6
Northeast	39.1	21.6	60.9	78.4
New England	35.5	28.9	64.5	71.1
Middle Atlantic	40.0	17.8	60.0	82.2
North Central	35.6	13.2	64.5	86.8
East North Central	31.5	12.1	68.5	87.9
West North Central	49.1	14.3	50.9	85.7
South	41.2	30.6	58.8	69.4
South Atlantic	42.9	31.0	57.1	69.0
East South Central	41.5	32.6	58.5	67.4
West South Central	38.8	27.6	61.2	72.4
West	44.1	32.8	55.9	67.2
Mountain	45.5	28.4	54.5	71.6
Pacific	43.8	37.9	56.2	62.1

Source: 15

MORE THAN THREE-FOURTHS OF ALL NONMETROPOLITAN PROVIDER AGENCIES WERE HEALTH DEPARTMENTS (TABLE 27)

- The bulk of agencies operating family planning programs in nonmetropolitan areas are health departments—but they generally have very small caseloads.
- Very few Planned Parenthood affiliates are found outside of SMSAs; they comprise only four percent of nonmetropolitan providers.
- Planned Parenthood and other agencies tend to operate more clinic sites than health departments. Of the 2,488 nonmetropolitan clinic sites, eight percent are operated by Planned Parenthood and 21 percent by other agencies.

A SMALL NUMBER OF AGENCIES SERVE THE BULK OF THE FAMILY PLANNING CASELOAD IN NONMETROPOLITAN AREAS (TABLE 28)

- About 17 percent of nonmetropolitan provider agencies serve half of the nonmetropolitan caseload. These 239 agencies with more than 1,000 patients include most of the 22 nonmetropolitan Planned Parenthood affiliates.
- Most of the nonmetropolitan agencies have very small caseloads—and the bulk of all nonmetropolitan patients are served by small health department programs.

Table 27. Number and Percent Distribution of Direct Providers of Family Planning Services, by Agency Type and Metropolitan Status and by Site Type, 1975.

	Total U.S.		Metropolitan		Nonmetropolitan	
Type of Agency	Number	Percent	Number	Percent	Number	Percent
All agencies	2,516	100	1,113	100	1,403	100
Hospital	347	13.8	291	27.2	56	4.1
Health Department	1,474	58.6	365	33.3	1,109	76.7
Planned Parenthood	171	6.8	149	11.2	22	3.6
Other	524	20.8	308	28.1	216	15.5

Number and Percent Distribution of Family Planning Clinic Sites, by Site Type and Metropolitan Status, 1975.

	Total U.S.		Metropolitan		Nonmetropolitan	
Type of Site	Number	Percent	Number	Percent	Number	Percent
Total Sites	5,273	100	2,785	100	2,488	100
Hospital	447	8.4	363	13.0	84	3.4
Health Department	3,019	57.2	1,344	48.3	1,675	67.3
Planned Parenthood	764	14.5	566	20.3	198	8.0
Other	1,043	19.8	512	18.4	531	21.3

Source: 15

Table 28. The Distribution of Family Planning Agencies in Nonmetropolitan Areas by the Size of the Caseload and Number of Low- and Marginal-Income Patients, 1975.

	Agencies		Patients		Percent of Patients by Type of Agency				
Size of Caseload	Number	Percent	Number (000's)	Percent	Total	Hospital	Health Department	Planned Parenthood	Other
Total	1,403	100	858*	100	100	4	68	7	20
5,000 or more	4	...	26	3	100	25	22	31	22
2,000-4,999	57	4	159	19	100	2	45	22	31
1,000-1,999	178	13	244	28	100	4	67	6	23
500-999	335	24	232	27	100	3	79	...	18
100-499	667	47	189	22	100	4	85	...	11
50-99	91	7	6	1	100	6	79	0	15
1-49	71	5	2	...	100	5	78	0	17

... Less than 1.0 percent.

*About 6,600 low- and marginal-income nonmetropolitan patients were served by agencies located in metropolitan areas.

Source: 15

REGIONS SHOW GREAT DIVERSITY IN TYPES OF AGENCIES PROVIDING SERVICES (TABLE 29)

- The family planning service delivery network in nonmetropolitan areas is different from that in metropolitan areas, nevertheless health departments account for the highest proportion of both metropolitan and nonmetropolitan agencies and sites—66 percent of nonmetropolitan and 36 percent of metropolitan family planning patients receive this service from a health department.

- These percentages vary a great deal from region to region, with percent of nonmetropolitan women served by health departments varying from 13 percent in the Middle Atlantic area to 91 percent in the South Atlantic states.

- Hospitals provide service to a very small percentage of nonmetropolitan women, ranging up to 13 percent in the Mountain area; no hospitals provide services in nonmetropolitan New England or East South Central area.

- While Planned Parenthood affiliates are largely based in metropolitan areas, in the New England and Middle Atlantic areas, Planned Parenthood serves more than one-third of all nonmetropolitan patients.

- Other types of providers such as community action agencies are more often located in nonmetropolitan areas and in New England; they provide two-thirds of the services.

Table 29. Number of Patients Served by Organized Family Planning Programs and Percent Distribution by Type of Agency, by Region and Metropolitan Status, 1975 (numbers in 000's).

Region and Metropolitan Status	Number of Patients	Percent Served, by Agency				
		Total	Hospital	Health Department	Planned Parenthood	Other*
U.S. Total	3,924	100	15	41	26	16
Metropolitan	2,955	100	18	36	31	15
Nonmetropolitan	969	100	4	66	11	19
New England	170	100	21	4	22	53
Metropolitan	130	100	27	6	19	48
Nonmetropolitan	39	100	0	0	33	67
Middle Atlantic	632	100	29	13	40	18
Metropolitan	583	100	31	13	40	16
Nonmetropolitan	49	100	6	13	47	34
East North Central	477	100	10	23	50	17
Metropolitan	415	100	11	20	54	14
Nonmetropolitan	62	100	1	43	21	35
West North Central	261	100	17	29	31	23
Metropolitan	188	100	21	30	34	15
Nonmetropolitan	73	100	9	25	24	42
South Atlantic	746	100	10	75	9	6
Metropolitan	476	100	14	66	14	6
Nonmetropolitan	270	100	3	91	0	6
East South Central	369	100	4	84	7	5
Metropolitan	190	100	7	78	11	4
Nonmetropolitan	179	100	0	90	3	7
West South Central	486	100	8	51	22	19
Metropolitan	345	100	11	44	28	17
Nonmetropolitan	141	100	2	66	8	24
Mountain	188	100	13	40	37	10
Metropolitan	132	100	12	39	47	2
Nonmetropolitan	71	100	13	43	20	24
Pacific	582	100	17	38	25	20
Metropolitan	496	100	19	33	27	21
Nonmetropolitan	86	100	6	67	11	16

*Other agencies include community action agencies, neighborhood health centers, etc.
Source: 15

Abortion Services

ONLY FIVE PERCENT OF ALL LEGAL ABORTIONS WERE OBTAINED IN NON-METROPOLITAN AREAS (TABLE 30)

- In 1976, about 59,000 legal abortions were performed in nonmetropolitan areas, one out of 20 provided in the U.S. Yet one in four women in need of abortions live in those areas.
- The 496 nonmetropolitan providers were primarily 408 hospitals, each with very small numbers of abortions provided; the other identified providers were 29 free-standing clinics and 59 private physicians who performed abortions in their offices.
- The abortion rate in nonmetropolitan areas, 4.1 abortions per 1,000 women, was one-eighth of the metropolitan abortion rate—however, some nonmetropolitan women undoubtedly used metropolitan facilities.
- Of the 317,000-443,000 nonmetropolitan women who were estimated to need abortion services in one year, only 14 to 19 percent obtained them in 1976.

THE LARGER THE COMMUNITY, THE HIGHER THE ABORTION RATE (FIGURE 31)

- The largest SMSAs have abortion rates far in excess of the smallest SMSAs. Nonmetropolitan area rates were much less than in SMSAs of any size.
- The abortion rate in nonmetropolitan areas is increasing while the rate in the largest SMSAs is decreasing, indicating a slightly improved distribution of abortions in relation to the location of the population in need of abortions.

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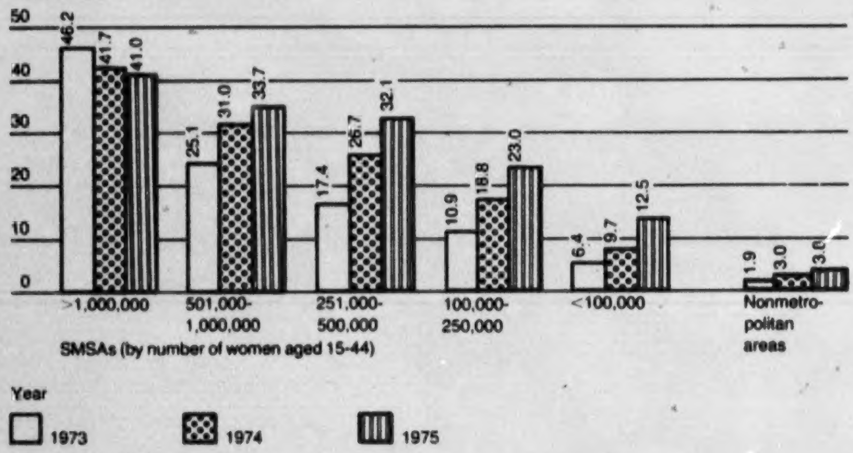
Table 30. Number of Reported Legal Abortions, Number of Providers, Rate of Abortions Per 1,000 Women Aged 15-44, Ratio of Abortions Per 1,000 Live Births and Percent of Estimated Need (Higher Estimate) for Abortions That Were Met, by Metropolitan Status, 1973-1976.

Measure	1973	1974	1975	1976*
Number of Reported Abortions (000's)				
U.S. Total	744.6	898.6	1,034.2	1,115.0
Metropolitan	719.7	857.3	980.5	1,055.0
Nonmetropolitan	24.9	41.3	53.6	59.0
Number of Providers				
U.S. Total	1,627	1,028	2,398	np
Metropolitan	1,301	1,614	1,902	np
Nonmetropolitan	326	414	496	np
Abortion Rate (Per 1,000 Women)				
U.S. Total	16.6	19.6	22.1	23.3
Metropolitan	22.7	26.6	30.0	31.7
Nonmetropolitan	1.9	3.0	3.8	4.1
Abortion Ratio (Per 1,000 Live Births)				
U.S. Total	239	282	331	358
Metropolitan	343	402	468	492
Nonmetropolitan	25	39	52	56
Percent Met Need				
U.S. Total	42	51	59	63
Metropolitan	54	65	74	79
Nonmetropolitan	6	9	12	14

*Projected
Source: 17

Figure 31. Rate of reported abortions per 1,000 women aged 15-44, by metropolitan status and size of SMSA, 1973-1975

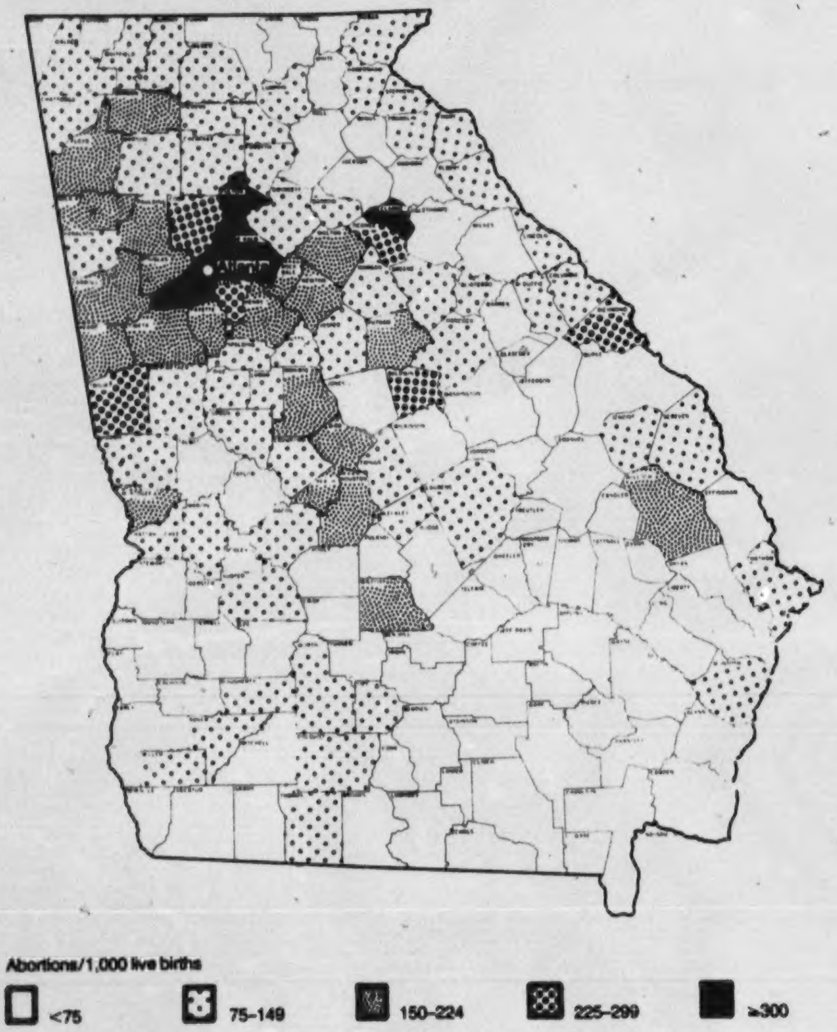


Source: 17

THE FURTHER WOMEN HAD TO TRAVEL TO OBTAIN AN ABORTION, THE LESS LIKELY THEY WERE TO GET ONE (FIGURE 32)

- County of residence was matched with county where abortion was obtained in the state of Georgia in 1974.
- Abortion ratios (abortions per 1,000 live births) were considerably higher as the distance to abortion facilities narrowed.
- Distance appeared to have the most significant effect on black teenagers.

Figure 32. Number of Abortions Per 1,000 Live Births, by County of Residence, Georgia, 1974


Abortions/1,000 live births
<75
75–149
150–224
225–299
≥300

Source: 18

ALMOST HALF OF NONMETROPOLITAN ABORTIONS WERE PROVIDED BY FREE-STANDING CLINICS (TABLE 33)

- Of the 16,000 nonmetropolitan abortions reported in the first quarter of 1976, 46 percent were provided by clinics, 26 percent by private hospitals, 17 percent by public hospitals and 11 percent by private physicians.
- The trend since 1973 in both metropolitan and nonmetropolitan areas has been toward greater utilization of free-standing clinics. In 1973, only 19 percent of all nonmetropolitan abortions were reported by clinics—since then the caseload has grown six-fold.
- Of the 2,825 non-Catholic short term general hospitals in nonmetropolitan areas, only 14 percent provide abortion services:

	Total Number	Providers	
		Number	Percent
Public Hospitals	1,404	142	10
Private Hospitals	1,421	266	19

Table 33. Distribution of Abortions by Type of Provider and Metropolitan/Nonmetropolitan Occurrence, 1973-1975 and 1st Quarter, 1976 (numbers in 000's).

	1st Quarter 1976		Year 1975		Year 1974		Year 1973	
Total	Number	Percent	Number	Percent	Number	Percent	Number	Percent
U.S. Total	285	100	1,034	100	900	100	744	100
Public Hospital	23	8	92	9	96	11	89	12
Private Hospital	82	29	321	31	320	36	306	41
Clinics	170	60	586	57	459	51	331	45
Private Physicians' Offices	10	3	35	3	25	3	18	2
Metropolitan Total	269	100	980	100	859	100	721	100
Public Hospital	21	8	82	8	87	10	79	11
Private Hospital	77	29	306	31	306	36	325	45
Clinics	163	61	562	57	445	52	310	43
Private Physicians' Offices	8	3	30	3	21	2	7	1
Nonmetropolitan Total	16	100	53	100	41	100	23	100
Public Hospital	3	17	10	19	9	22	7	29
Private Hospital	4	26	15	28	14	34	10	43
Clinics	7	46	23	44	14	34	4	16
Private Physicians' Offices	2	11	5	10	4	10	2	9

Source: 19

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APPENDIX B

RESPONSE FROM EDWARD D. MARTIN, M.D., ASSISTANT SURGEON GENERAL AND DIRECTOR, BUREAU OF COMMUNITY HEALTH SERVICES

As requested during the discussion of *Rural Family Planning Programs: The Administrative Perspective*, a letter containing questions which were directed to Dr. Martin's presentation was sent to him. Following are the questions and his responses:

1. How does the BCHS Regional Memorandum 77-25 affect the current rural family planning projects which provide quality care but have administrative costs in excess of 20 percent?

   The Bureau's administrative cost policy applies across the board to all BCHS health services projects throughout the United States. Any project that has been operational for more than 24 months, i.e., providing services and receiving Federal grant funds, is expected to comply with the 20 percent standard. However, a project's administrative costs may range up to 22 percent and still be in compliance if the Regional Office believes there are circumstances justifying this level of administrative costs.

2. Can you provide the means by which the 20 percent was found to be relevant to the field of family planning and the sources of information from which you drew your conclusion that 20 percent needed to be used as a penalty for services expansion in family planning?

   Two specific elements were used in determining the 20 percent norm for administrative costs for BCHS ambulatory health care projects. The Bureau relied on a basic cost model for ambulatory health care centers, and looked at cost data for providers of ambulatory health care. The original assumptions behind the establishment of the administrative cost indicator, as well as experience to date with the indicator, suggest that it is appropriate for Title X projects.

   The basic cost model assumes one full-time equivalent primary care provider (one physician or two mid-level practitioners) with three full-time equivalent support staff. This complement of primary care staff would have the capacity to generate approximately $100,000 in annual gross charges. The model assumes that the four full-time equivalent staff would have salaries approximating $80,000 ($40,000 for the primary care provider and $13,000 per support person). Assuming that the goal is for the gross charges to equal or exceed the costs of the center, there would be approximately $20,000 left for general services and other support activities. The assumption that costs and gross charges would be equal is based on the requirement that all ambulatory health care centers receiving grant support from the Bureau, including Title X projects, have fee schedules that reasonably relate to the center's costs.

   In addition, the Bureau looked at the administrative costs of federally funded and nonfederally funded providers of ambulatory health care. The majority of ambulatory health care centers funded by the Bureau historically have had overhead costs that fall within the range of 15 to 25 percent. While the Bureau has only recently begun to collect cost data from family planning providers, the initial experience indicates that family planning costs approximate the cost distribution of other Bureau providers of health care:

	Family Planning Projects	Community Health Centers	Migrant Health Centers
Direct Health Care	60%	65%	60%
Supporting Activities	15%	11%	13%
Administrative Overhead	25%	24%	27%
Total Costs	100%	100%	100%

   The Bureau also looked at the experience of prepaid group practices and out-patient programs of hospitals. These organizations budget for administrative costs in the range of 10 to 15 percent, considerably less than the cost standard used by the Bureau.

3. When the comprehensive health clinics were looked at that were supposed to be very efficient operations, was a uniform audit done on each one of them? Please explain the methodology.

   From 1972 to 1974, the Public Health Service had contracts with Wolf and Company to conduct cost validations of all comprehensive health centers. As one result of this contractual activity, the Bureau developed a cost validation protocol (copy enclosed) that was used by the Regional Offices to validate the cost data Community Health Centers reported to the Regional Offices and the Bureau. In 1976 when the revised regulations for the Community Health Centers and Migrant Health Programs were published, they contained the requirement that each grantee under these program authorities have an annual certified public accountant audit.

4. In many communities family planning is the drawing card for health services; at this time isn't it easier to build more comprehensive services into a family planning clinic than to build family planning into a more comprehensive setting?

   Both approaches are clearly needed and should be done. Family planning is a crucial and necessary ingredient of good primary care services provided to members of the family. Also, we must look more broadly at family planning providers to see how these points of care can be expanded to become more family oriented services or more broadly based adolescent services.

   We have already seen many family planning grantees move into more comprehensive kinds of services through the addition of services to meet the broader reproductive health care needs of women as well as activities

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designed to involve males. We clearly need to encourage them to expand their range of services and compete for grant support from some of the other BCHS programs under which this broader range of services may be funded.

5. Can you tell us how the RHI would be financed?

The Rural Health Initiative (RHI) will have two grant review cycles during fiscal year 1978. Resources available through the RHI will consist of approximately 10.6 million dollars in Section 330, Community Health Center Program funds, and 3.0 million dollars in Section 319, Migrant Health Center Program funds. Moreover, approximately 3.5 million dollars in Title XIX funds will be available to support new Health Underserved Rural Area (HURA) projects.

Grant reviews for the first cycle are nearly completed. Applications were due into the HEW Regional Offices in November 1977 and funds will be transferred to the Regional Offices for grant awards on February 15, 1978. Second cycle grant applications are due April 14, 1978, and the Central Office will allocate funds by August 1, 1978, for the approved applications.

The allocation of Section 330 and Section 319 funds through the RHI will be done in part according to the following formula. Priority for allocation of Section 330 funds will go to rural (non-Standard Metropolitan Statistical Areas) counties that meet three or four of the RHI need criteria, i.e., Medically Underserved Areas (MUA), Critical Health Manpower Shortage Areas (CHMSA), areas with high infant mortality, and areas with high concentrations of migrant and seasonal farmworkers, and which do not currently have assistance from other BCHS programs. Preference for the allocation of Section 319 funds will focus on 50 areas across the country with substantial (1,500 or more) migrant farmworker populations that are currently unserved by BCHS primary care projects.

Priority for the allocation of HURA Title XIX funds will go to hospitals, private group practices, and State and county health departments (i.e., experienced, self-sufficient provider organizations) capable of expanding their current primary care system into adjacent medically underserved communities. HURA priority will also be given to State Medicaid organizations wishing to examine the impact of Medicaid eligibility requirements and reimbursement policies on the health status of rural residents.

RHI Section 330 and 319 funds awarded to grantees must be used to provide a full range of primary care services, including family planning, as described in the law and the Federal regulations implementing the law. Although the provision of family planning services is not a requirement of the HURA Program, all primary care projects administered by the Bureau are required to integrate these services with a number of categorical programs, including the Family Planning Program.